REPORTING REQUIREMENTS

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PREFACE 7001

Section 128735 of the Health and Safety Code requires hospitals to report annually specified financial and statistical data on forms specified by this Office. The forms included within this chapter represent the reporting requirements of each hospital to this Office.

Section 97041, Title 22, of the California Code of Regulations requires all hospitals to submit the Office's Annual Hospital Disclosure Report in a standard electronic format, as defined by the Office, rather than using hard-copy report forms. The software used for electronic filing must be in a standard electronic format, as defined by the Office, and pre-approved by the Office. Hospitals may elect to use approved software developed by a third party or by the hospital. After completing annual disclosure reports using Office-approved report preparation software, hospitals must either 1) submit their annual disclosure reports on PC diskettes, or 2) transmit their annual disclosure reports by modem to the Office's Bulletin Board System (BBS). Please contact the Office of Statewide Health Planning and Development at (916) 323-0875 to receive a list of approved third party report preparation software vendors, or to receive the software for transmitting annual disclosure reports generated by Office-approved software by modem to the Office's BBS.

Although flexibility has been allowed in the accounting system for each hospital, the reporting requirements, as presented in the forms and the instructions thereto, are uniform for all hospitals.

The balance sheet account groupings, indicated in the Chart of Accounts by a fourth digit of zero (i.e., XXX0.XX) must be reported.

All cost and revenue centers having a fourth primary digit of "0", whose functions are performed in the hospital, must be reported. As noted in Sections 2120, 2130 and 2140 certain non-zero level accounts are reportable accounts. As noted in the Cost Finding chapter of this Manual, certain reclassifications will be necessary if a hospital performs or records the required revenue and cost center functions in other cost centers. For example, if all laboratory functions are performed in one cost center and because the costs, revenue, and statistics of that cost center are not segregated into the functional centers required in the Manual, a reclassification of the cost center's expense, revenue, and statistics will be necessary.

Reports must be submitted by all hospitals (Division 1, Part 1.8, Section 443.31 of the Health and Safety Code) for all annual accounting periods.

A report must be completed and submitted annually to this Office within four months after the close of the hospital's annual accounting period. In order to be considered complete, all required report pages must be correctly filled out, in accordance with instructions. Any hospital which does not file all report pages completed as required is liable for civil penalty of one hundred dollars ($100) a day for each day the filing of the disclosure report with the Office is delayed, considering all extension days granted by the Director of the Office.

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Short period reports must be filed by hospitals which have been in operation for less than one year (if the first accounting period is less than one year). When the licensure of a hospital changes during the year, a report must be filed with this Office by the former licensee for the period of their ownership, and a report filed by the new licensee for their first accounting period (this may be a short period).

All reports must be submitted to the:

Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
818 K Street, Room 400
Sacramento, California 95814

This chapter contains a listing of all report pages, instructions to the report pages, and a reduced set of the disclosure report pages.

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LIST OF REPORTING FORMS 7010

For report periods ending on or before June 29, 2000:

Form No.	Report Page	Title	Preparation Sequence
CHC 7041 h-1	0	General Information and Certification	23
CHC 7041 h-2	1	Hospital Description	12
CHC 7041 h-3	2	Services Inventory	13
CHC 7041 h-4	3.1-3.4	Related Hospital Information	14
CHC 7041 h-5	4.1	Patient Census Statistics	15
CHC 7041 h-5	4.2	Ambulatory, Ancillary and Other Utilization Statistics	16
CHC 7041 a-1	5	Balance Sheet - Unrestricted Fund	17
CHC 7041 a-1	5.1	Supplemental Long-Term Debt Information	18
CHC 7041 a-3	5.2	Statement of Changes in Property, Plant, Equipment Balances	19
CHC 7041 b-1	6	Balance Sheet - Restricted Funds	20
CHC 7041 c-1	7	Statement of Changes in Equity	21
CHC 7041 d-1	8	Statement of Income - Unrestricted Fund	11
CHC 7041 d-1	8.1	Statement of Income - Unrestricted Fund (Non-Operating Revenue and Expense)	10
CHC 7041 e-1	9	Statement of Cash Flows - Unrestricted Fund	22
CHC 7041 d-3	12	Supplemental Patient Revenue Information	1
CHC 7041 d-5	14	Supplemental Other Operating Revenue Information	2
CHC 7041 d-6	15	Reclassification Worksheet - Physician and Student Compensation - Patient Revenue Producing Centers	3
CHC 7041 d-7	16	Reclassification Worksheet - Physician and Student Compensation - Non-Revenue Producing Centers	3
CHC 7041 d-8	17	Trial Balance Worksheet and Supplemental Expense Information - Patient Revenue Producing Centers	4
CHC 7041 d-9	18	Trial Balance Worksheet and Supplemental Expense Information - Non-Revenue Producing Centers	4
CHC 7041 g-2	19a	Cost Allocation - Statistical Basis Short Form	7
CHC 7041 g-1	19	Cost Allocation - Statistical Basis	8
CHC 7041 f-1	20	Cost Allocation	7
CHC 7041 f-1	20a	Cost Allocation Short Form	9

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Form No.	Report Page	Title	Preparation Sequence
CHC 7041 h-6	21	Detail of Direct Payroll Costs - Patient Revenue Producing Centers	5
CHC 7041 h-7	21.1	Detail of Direct Contracted Costs - Patient Revenue Producing Centers	6
CHC 7041 h-8	22	Detail of Direct Payroll Costs - Non-Revenue Producing Centers	5
CHC 7041 h-9	22.1	Detail of Direct Contracted Costs - Non-Revenue Producing Centers	6

For report periods ending on or after June 30, 2000:

Form No.	Report Page	Title	Preparation Sequence
CHC 7041 h-1	0	General Information and Certification	22
CHC 7041 h-2	1	Hospital Description	11
CHC 7041 h-3	2	Services Inventory	12
CHC 7041 h-4	3.1-3.4	Related Hospital Information	13
CHC 7041 h-5	4	Patient Utilization Statistics	14
CHC 7041 h-5	4.1	Patient Census Statistics by Payer	15
CHC 7041 a-1	5	Balance Sheet - Unrestricted Fund	16
CHC 7041 a-1	5.1	Supplemental Long-Term Debt Information	17
CHC 7041 a-3	5.2	Statement of Changes in Property, Plant, Equipment Balances	18
CHC 7041 b-1	6	Balance Sheet - Restricted Funds	19
CHC 7041 c-1	7	Statement of Changes in Equity	20
CHC 7041 d-1	8	Statement of Income - Unrestricted Fund	10
CHC 7041 e-1	9	Statement of Cash Flows - Unrestricted Fund	21
CHC 7041 d-3	12	Supplemental Patient Revenue Information	1
CHC 7041 d-5	14	Supplemental Other Operating Revenue Information	2
CHC 7041 d-6	15	Reclassification Worksheet - Physician and Student Compensation - Patient Revenue Producing Centers	3
CHC 7041 d-7	16	Reclassification Worksheet - Physician and Student Compensation - Non-Revenue Producing Centers	3
CHC 7041 d-8	17	Trial Balance Worksheet and Supplemental Expense Information - Patient Revenue Producing Centers	4

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Form No.	Report Page	Title	Preparation Sequence
CHC 7041 d-9	18	Trial Balance Worksheet and Supplemental Expense Information - Non-Revenue Producing Centers	4
CHC 7041 g-2	19a	Cost Allocation - Statistical Basis Short Form	7
CHC 7041 g-1	19	Cost Allocation - Statistical Basis	8
CHC 7041 f-1	20	Cost Allocation	7
CHC 7041 f-1	20a	Cost Allocation Short Form	9
CHC 7041 h-6	21	Detail of Direct Payroll Costs - Patient Revenue Producing Centers	5
CHC 7041 h-7	21.1	Detail of Direct Contracted Costs - Patient Revenue Producing Centers	6
CHC 7041 h-8	22	Detail of Direct Payroll Costs - Non-Revenue Producing Centers	5
CHC 7041 h-9	22.1	Detail of Direct Contracted Costs - Non-Revenue Producing Centers	6

REPORTING REQUIREMENTS

INSTRUCTIONS FOR COMPLETING REPORTING FORMS 7020

These instructions relate to the Hospital Disclosure Report for the reporting periods ending on or after December 31, 1992.

Reports must be submitted by all hospitals licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code.

The following rules apply to completing and submitting the Hospital Disclosure Report:

1. One original and one legible copy of the disclosure report must be submitted to the Office within four months after the end of each reporting period by the organization which operated the facility during the reporting period. The reporting period ends: (a) at the close of the hospital's annual accounting period fiscal year, (b) on the last day of patient care when the hospital no longer accepts patients, (c) on the last day of patient care at the old plant when the hospital closes to relocate to a new plant, or (d) on the last day of licensure of the entity relinquishing the license when there is a change in licensee.

   Hospitals must prepare annual disclosure reports using the latest Office-approved report preparation software, rather than using hard-copy report forms. Hospitals may elect to submit their annual disclosure reports generated by Office-approved report preparation software either 1) on PC diskettes or 2) by transmitting them by modem to the Office's Bulletin Board System (BBS). Hospitals which are unable to meet the Office's electronic reporting requirements must obtain written approval from the Office to use hard-copy report forms. When submitting your disclosure report using one of the Office-approved PC diskette systems, send only one copy of the appropriate diskette and two signed copies of the system-produced certification. You do not need to send a copy of the system-generated facsimile report. When transmitting your annual disclosure report by modem to the Office's BBS, you must still mail a copy of the signed certification produced by the report preparation software. If you have received written approval from the Office to use hard-copy report forms, send the original and one copy of the completed report.

   The licensee is responsible for reporting for the entire period of licensure, even if there is an agreement between the parties on a change in licensee for the new licensee to operate the facility prior to the new license being effective. However, a reporting modification would be considered if a new licensee wants to report for a period which begins prior to the effective date of the license and for the reporting period of the entity relinquishing

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the license to end prior to the last day of its licensure. If there are special situations which are not covered by the above, each situation will be handled on a case-by-case basis.

2. Hospitals must obtain specific written Office approval to submit reports exceeding 12 months.

3. The reports must be legibly completed by typewriter, in black ink, or soft lead pencil. Reports completed in blue ink or hard lead pencil which are not readable when reproduced will be returned for recopying. Reduced copies will not be accepted and will be returned.

4. In order to be considered complete, all required pages must be correctly and completely filled out in accordance with the instructions which follow.

5. Reports submitted to the Office are not required to be audited. However, hospitals are encouraged to complete their year-end audits prior to completing this report.

6. All amounts shall be reported in whole dollars unless otherwise indicated.

7. Any hospital which does not file all report pages with the Office, completed as required and postmarked on or before the due date (allowing for all approved extensions), will be fined a civil penalty of one hundred dollars ($100) a day for each day the filing of such report is delayed.

8. Partial fiscal year reports must be filed by hospitals which have been in operation for less than one year at the end of their fiscal year.

9. When the licensure of the hospital changes during the annual financial year, the disclosure report must be filed with the Office by the former licensee for the period of their ownership, and a report filed by the new licensee for their first, and subsequent, accounting periods. The first accounting period may be a partial fiscal year.

10. No line or column descriptions are to be changed under any circumstances. If an item doesn't fit the items specified, include such item in an "other" category, e.g., Other Ancillary Services, Other Current Assets.

The instructions for the report pages generally follow the preparation sequence of the pages rather than the page number sequence of the forms. For your assistance Section 7010 has the recommended preparation sequence for completing the disclosure report pages.

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RECLASSIFICATIONS 7020.1

Although cost center reclassification columns are not provided on report pages 17 and 18, cost center reclassifications may still be needed to meet the uniform reporting requirements. In addition to cost center reclassifications, revenue and units of service (standard units of measure) may also need reclassification. In such cases, needed reclassifications must be made before the revenue, units of service, and expenses are entered on the report on pages. Worksheets supporting and documenting such reclassifications are not required to be filed with the disclosure report but must be maintained as a part of the hospital's records.

Reclassification, as defined in Chapter 5000, of revenues and expenses, may be necessary to achieve the uniform disclosure reporting requirements of this Manual. Revenue and statistics reclassifications must be separated as to inpatient and outpatient and as to payer (See Manual Section 7020.2 for a list of the payer categories). Outpatient statistics for ancillary centers must be reclassified by outpatient classification to meet the requirements of report page 4.2. Expense (cost center) reclassifications must be separated into eight major natural classifications: salaries (.00-.09), employee benefits (.10-.19); professional fees (.20-.29); supplies (.30-.59); purchased services (.60-.69); depreciation (.71-.74): leases and rentals (.75-.76); and other direct expenses (.77-.90).

Reclassifications will usually be made for one of three reasons:

A. To achieve the required level of reporting. If the hospital provides services which are required to be reported separately, and these services are combined with others, a reclassification will be required. An example of this type would be where all laboratories are grouped into one cost center. The Manual requires separate reporting for clinical, pathological, and pulmonary function labs. Therefore, a reclassification to achieve the required level of reporting is necessary.

B. To correct for dislocated patients. Revenue, statistics, and expenses associated with a particular type of patient (pediatrics acute, obstetrics acute, medical/surgical acute, etc.) must be reported in the proper functional cost center irrespective of the actual location and treatment of the patient. For example, acute patients are occasionally placed in an intensive care bed when acute beds are filled to capacity. The expenses and possibly the revenue and statistics would be reclassified to correct for these dislocated patients.

C. To correct for dislocated functions. Revenue, statistics and expenses associated with a particular function must be reported in the proper cost center as defined in this Manual. For example, if the pharmacy administers I.V. solutions to patients (a function of the appropriate nursing cost center as defined in Section 2420.1), a reclassification would be required.

NOTE: Reclassifications must not be used for posting trial balance amounts. Any expenses, revenue, and units of service which must be added to the trial balance figures must be entered on the books of the hospital.

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Page 12 SUPPLEMENTAL PATIENT REVENUE INFORMATION 7020.2

For report periods ending on or before June 29, 2000, complete report page 12 following the instructions specified in Instruction No. 1. For report periods ending on or after June 30, 2000, complete report page 12 following the instructions specified in Instruction No. 2.

Instruction No. 1 (Report Periods ending on or before June 29, 2000)

This page requires that gross inpatient and outpatient revenue be reported by revenue center by revenue source, Medicare, Medi-Cal, County Indigent Programs Third-Parties, and Other Payors. Deductions from revenue must be reported by Medicare, County Indigent Programs, Third-Parties, and Other Payors by inpatient and outpatient on page 12. Total Medi-Cal deductions from revenue must also be reported. The hospital must report revenue for each line (revenue center) on page 12 if there was revenue produced for the functions listed.

The hospital may have combined certain accounts (functions), but for reporting purposes each must be reported separately. As an example, Coronary Care revenue may have been combined with Medical/Surgical Intensive Care revenue on the books, however, for reporting purposes, the revenue for each must be separately reported. The revenue must be reclassified prior to reporting on page 12. A separate worksheet will be necessary to reclassify any applicable amounts. This worksheet need not be submitted with the disclosure report to the Office but must be maintained as part of the hospital's records.

All hospitals, including inclusive rate hospitals, must complete steps 1 through 33, as applicable. Prior to completing the following steps, inclusive rate hospitals must reclassify revenue from the hospital's revenue service categories to the standard revenue centers on page 12 using the cost ratios developed by cost studies performed in establishing the inclusive rates. Worksheets supporting such reclassifications need not be submitted but must be maintained as a part of the hospital's records. Please refer to Sections 2230 and 2430 of this Manual for subclassifications of patient service revenue accounts and deductions from revenue. For reporting purposes the following chart indicates the groupings of subclassification of revenue and deductions for revenue by payor category.

Payor	Financial Status Classification
Medicare	.X4
Medi-Cal	.X5
County Indigent Programs	.X7
Third-Parties	.X1, .X2, .X3, and .X6
Other Payors	.X0, .X8 and .X9

1. Enter gross Medicare inpatient and outpatient revenue (revenue subclassification .X4) by revenue center, after reclassification, in columns 1 and 3, respectively.

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2. Enter gross Medi-Cal inpatient and outpatient revenue (revenue subclassification .X5) by revenue center, after reclassification, in columns 5 and 7, respectively.

3. Enter gross County Indigent Programs inpatient and outpatient revenue (revenue subclassification .X7) by revenue center, after reclassification, in columns 9 and 11, respectively.

4. Enter Third-Parties inpatient and outpatient gross revenue (revenue subclassifications .X1, .X2, .X3, and .X6) by revenue center, after reclassification, in columns 13 and 15, respectively.

5. Enter Other Payors inpatient and outpatient gross revenue (revenue subclassifications .X0, .X8 and .X9) by revenue center, after reclassification; in columns 17 and 19.

6. Enter total gross inpatient revenue (sum of columns 1, 5, 9, 13, and 17) by revenue center in column 21.

7. Enter total gross outpatient revenue (sum of columns 3, 7, 11, 15 and 19) by revenue center in column 23.

8. Enter total gross patient revenue (sum of columns 21 and 23) by revenue center in column 25.

9. Total lines 5 through 145 of each daily hospital services column on line 150. Total lines 160 through 220 of each ambulatory services column on line 225. Total lines 230 through 400 of each ancillary services column on line 405. Enter the total of lines 150, 225, 405, and 410 on line 415.

10. The total daily hospital services revenue on line 150, column 25 must equal page 8, column 1, line 5.

11. The total ambulatory services revenue on line 225, column 25, must equal page 8, column 1, line 10.

12. The total ancillary services revenue on line 405, column 25, must equal page 8, column 1, line 15.

13. The total purchased inpatient services revenue on line 410, column 25, must equal page 8, column 1, line 20.

14. The total patient revenue on line 415, column 25 must equal page 8, column 1, line 30.

15. Enter the Provision for Bad Debts (e.g. Account 5800.00 would be recorded in the other payor inpatient column) for each payor

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classification on line 420, columns 1 through 19, except in columns 5 and 7. In column 5, enter total Bad Debts related to Medi-Cal.

16. Enter the inpatient Medicare contractual adjustments (Account 5810.04 - including prior year Medicare cost reimbursement settlements, if any) on line 425, column 1.

17. Enter the outpatient Medicare contractual adjustments (including prior year Medicare cost reimbursement settlements, if any) on line 425, column 3. The total of lines 425, column 1 and 3 must equal page 8, column 1, line 40.

18. Enter total Medi-Cal contractual adjustments (Accounts 5820.05 and 5820.45 - including prior year Medi-Cal cost reimbursement settlements, if any) on line 425, column 5. This item must equal page 8, column 1, line 45.

19. Enter the inpatient County Indigent Programs contractual adjustments (Account 5830.07) on line 425, column 9.

20. Enter the outpatient County Indigent Programs contractual adjustments on line 425, column 11. The total of line 425 columns 9 and 11 must equal page 8, column 1, line 50.

21. Enter the inpatient Third-Parties contractual adjustments (Account 5840.01 - including settlements on risk sharing agreements, if any) on line 425, column 13.

22. Enter the outpatient Third-Parties contractual adjustments (including settlements on risk sharing agreements, if any) on line 425 column 15. The total of line 425 columns 13 and 15 must equal page 8, column 1, line 55.

23. Enter the inpatient Other Payors contractual adjustments (Account 5850.09) on line 425, column 17.

24. Enter the outpatient Other Payors contractual adjustments on line 425, column 19. The total of line 425, column 17 and 19 must equal page 8, column 1, line 60.

25. Enter the total disproportionate share payments for Medi-Cal patient days (Account 5821) in column 5, line 426. This item must equal page 8, column 1, line 46. See Section 1270 of this Manual for more information on Medi-Cal disproportionate share payments.

26. Enter the inpatient and outpatient charity deductions from revenue (combine Accounts 5860 and 5870 by subclassification) on line

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430, columns 1 through 19, except in columns 5 and 7. In column 5, enter total charity deductions from revenue related to Medi-Cal.

27. Enter the inpatient capitation premium revenue (Account 5841.01) on line 427, column 13.

28. Enter the outpatient capitation premium revenue on line 427, column 15.

29. Enter the inpatient Restricted Donations and Subsidies for Indigent Care (Account 5880.09) on line 435, columns 9 and 17.

30. Enter the outpatient Restricted Donations and Subsidies for Indigent Care on line 435, columns 11 and 19.

NOTE: Steps 31 through 34 are to be completed only by the University of California teaching hospitals.

31. Enter the inpatient teaching allowances (Account 5890.09) on line 440, column 13.

32. Enter the outpatient teaching allowances on line 440, column 15.

33. Enter the inpatient support for clinical teaching (Account 5910.09) on line 445, columns 13.

34. Enter the outpatient support for clinical teaching on line 445, column 15.

35. Enter the inpatient and outpatient other deductions from revenue (Accounts 5970, 5980 and 5990) on line 450, columns 1 through 19, except for columns 5 and 7. In column 5, enter total other deductions from revenue related to Medi-Cal.

36. Enter the sum of lines 420 through 450 on line 455 for each column, except for column 7.

37. Enter total deductions from revenue (sum of columns 1 through 19) for lines 420 through 455 in column 25.

38. Enter the total net patient revenue on line 460 for each column, except columns 5 and 7, by subtracting total deductions from revenue on line 455 from total patient revenue on line 415. For line 460, column 5, subtract line 455, column 5, from the sum of line 415, columns 5 and 7.

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Instruction No. 2 (Report Periods ending on or after June 30, 2000)

This page requires that gross inpatient and outpatient revenue be reported by revenue center by revenue source, Medicare - Traditional, Medicare - Managed Care, Medi-Cal - Traditional, Medi-Cal - Managed Care, County Indigent Programs - Traditional, County Indigent Programs - Managed Care, Other Third Parties - Traditional, Other Third Parties - Managed Care, Other Indigent, and Other Payors. Deductions from revenue must be reported by Medicare - Traditional, County Indigent Programs - Traditional, Other Third Parties - Traditional, Other Indigent, and Other Payors by inpatient and outpatient on page 12. Also, total deductions from revenue must be reported by Medicare - Managed Care, Medi-Cal - Traditional, Medi-Cal - Managed Care, County Indigent Programs - Managed Care, and Other Third Parties - Managed Care on page 12. The hospital must report revenue for each line (revenue center) on page 12 if there was revenue produced for the functions listed.

The hospital may have combined certain accounts (functions), but for reporting purposes each must be reported separately. As an example, Coronary Care revenue may have been combined with Medical/Surgical Intensive Care revenue on the books, however, for reporting purposes, the revenue for each must be separately reported. The revenue must be reclassified prior to reporting on page 12. A separate worksheet will be necessary to reclassify any applicable amounts. This worksheet need not be submitted with the disclosure report to the Office but must be maintained as part of the hospital's records.

All hospitals, including inclusive rate hospitals, must complete steps 1 through 48, as applicable. Prior to completing the following steps, inclusive rate hospitals must reclassify revenue from the hospital's revenue service categories to the standard revenue centers on page 12 using the cost ratios developed by cost studies performed in establishing the inclusive rates. Worksheets supporting such reclassifications need not be submitted but must be maintained as a part of the hospital's records. Please refer to Sections 2230 and 2430 of this Manual for subclassifications of patient service revenue accounts and deductions from revenue. For reporting purposes the following chart indicates the groupings of subclassification of revenue and deductions for revenue by payor category.

Payer	Financial Status Classification
Medicare - Traditional	.04, .44
Medicare - Managed Care	.14, .54
Medi-Cal - Traditional	.05, .45
Medi-Cal - Managed Care	.15, .55
County Indigent Programs - Traditional	.07, .47
County Indigent Programs - Managed Care	.17, .57
Other Third Parties - Traditional	.02,.03, .06, .42, .43, and .46

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Payer	Financial Status Classification
Other Third Parties - Managed Care	.12, .13, .52, .53,
Other Indigent	.08, .48
Other Payors	.00, .09, .40, .49

1. Enter gross Medicare - Traditional inpatient and outpatient revenue (revenue subclassifications .04 and .44) by revenue center, after reclassification, in columns 1 and 2, respectively.

2. Enter gross Medicare - Managed Care inpatient and outpatient revenue (revenue subclassifications .14 and .54) by revenue center, after reclassification, in columns 3 and 4 , respectively.

3. Enter gross Medi-Cal - Traditional inpatient and outpatient revenue (revenue subclassifications .05 and .45) by revenue center, after reclassification, in columns 5 and 6, respectively.

4. Enter gross Medi-Cal - Managed Care inpatient and outpatient revenue (revenue subclassifications .15 and .55) by revenue center, after reclassification, in columns 7 and 8, respectively.

5. Enter gross County Indigent Programs - Traditional inpatient and outpatient revenue (revenue subclassifications .07 and .47) by revenue center, after reclassification, in columns 9 and 10, respectively.

6. Enter gross County Indigent Programs - Managed Care inpatient and outpatient revenue (revenue subclassifications .17 and .57) by revenue center, after reclassification, in columns 11 and 12, respectively.

7. Enter Other Third Parties - Traditional inpatient and outpatient gross revenue (revenue subclassifications .02, .03, .06, .42, .43, and .46) by revenue center, after reclassification, in columns 13 and 14, respectively.

8. Enter Other Third Parties - Managed Care inpatient and outpatient gross revenue (revenue subclassifications .12, .13, .42, and .43) by revenue center, after reclassification, in columns 15 and 16, respectively.

9. Enter Other Indigent inpatient and outpatient gross revenue (revenue subclassifications .08 and .48) by revenue center, after reclassification; in columns 17 and 18.

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10. Enter Other Payors inpatient and outpatient gross revenue (revenue subclassifications .00, .09, .40, .49) by revenue center, after reclassification; in columns 19 and 20.

11. Enter total gross inpatient revenue (sum of columns 1, 3, 5, 7, 9, 11, 13, 15, 17, and 19) by revenue center in column 21.

12. Enter total gross outpatient revenue (sum of columns 2, 4, 6, 8, 10, 12, 14, 16, 18, and 20) by revenue center in column 22.

13. Enter total gross patient revenue (sum of columns 21 and 22) by revenue center in column 23.

14. Total lines 5 through 145 of each daily hospital services column on line 150. Total lines 160 through 220 of each ambulatory services column on line 225. Total lines 230 through 400 of each ancillary services column on line 405. Enter the total of lines 150, 225, and 405 on line 415.

15. The total daily hospital services revenue on line 150, column 23, must equal page 8, column 1, line 5.

16. The total ambulatory services revenue on line 225, column 23, must equal page 8, column 1, line 10.

17. The total ancillary services revenue on line 405, column 23, must equal page 8, column 1, line 15.

18. The total patient revenue on line 415, column 23 must equal page 8, column 1, line 30.

19. Enter the Provision for Bad Debts (Account 5800 by subclassification, e.g. Account 5800.00 would be recorded in the other payor column) on line 420, columns 1 through 20.

20. Enter the inpatient Medicare - Traditional contractual adjustments (Account 5811.04 - including prior year Medicare cost reimbursement settlements, if any) on line 425, column 1.

21. Enter the outpatient Medicare - Traditional contractual adjustments (Account 5811.44 - including prior year Medicare cost reimbursement settlements, if any) on line 425, column 2.

22. Enter total Medicare - Managed Care contractual adjustments (Account 5812) on line 425, column 3.

23. Enter total Medi-Cal - Traditional contractual adjustments (Accounts 5821.05 and 5821.45 - including prior year Medi-Cal

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cost reimbursement settlements, if any) on line 425, column 5. This item must equal page 8, column 1, line 320.

24. Enter total Medi-Cal - Managed Care contractual adjustments (Account 5822) on line 425, column 7. This item must equal page 8, column 1, line 315.

25. Enter the inpatient County Indigent Programs - Traditional contractual adjustments (Account 5841.07) on line 425, column 9.

26. Enter the outpatient County Indigent Programs - Traditional contractual adjustments (Account 5841.47) on line 425, column 10.

27. Enter total County Indigent Programs - Managed Care contractual adjustments (Account 5842) on line 425, column 11.

28. Enter the inpatient Other Third Parties - Traditional contractual adjustments (Accounts 5851.02, 5851.03, and 5851.06) on line 425, column 13.

29. Enter the outpatient Other Third Parties - Traditional contractual adjustments (Accounts 5851.42, 5851.43, and 5851.46) on line 425, column 14.

30. Enter total Other Third Parties - Managed Care contractual adjustments (Account 5852) on line 425, column 15.

31. Enter the total disproportionate share payments for Medi-Cal patient days (Account 5830) in column 5, line 426. This item must equal page 8, column 1, line 325. See Section 1270 of this Manual for more information on Medi-Cal disproportionate share payments.

32. Enter total charity deductions from revenue (combine Accounts 5860 and 5870 by subclassification, e.g. Account 5860.08 would be recorded in the other indigent column) on line 430, columns 1 through 20.

33. Enter total Restricted Donations and Subsidies for Indigent Care (Account 5880 by subclassification, e.g. Account 5880.08 would be recorded in the other indigent column) on line 435, columns 1 through 20.

NOTE: Steps 34 through 37 are to be completed only by the University of California teaching hospitals.

34. Enter the inpatient teaching allowances (Account 5890.09) on line 440, column 19.

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35. Enter the outpatient teaching allowances (Account 5890.49) on line 440, column 20.

36. Enter the inpatient support for clinical teaching (Account 5910.09) on line 445, column 19.

37. Enter the outpatient support for clinical teaching (Account 5910.49) on line 445, column 20.

38. Enter total other deductions from revenue (Accounts 5920, 5930, and 5940 by subclassification, e.g. Account 5940.00 would be recorded in the other payor column) on line 450, columns 1 through 20.

39. Enter the sum of lines 420 through 450 on line 455 for each column.

40. Enter total deductions from revenue (sum of columns 1 through 20) for lines 420 through 455 in column 23.

41. Enter total Medicare capitation premium revenue (Account 5960 - including settlements on risk sharing agreements, if any) on line 457, column 3.

42. Enter total Medi-Cal capitation premium revenue (Account 5970 - including settlements on risk sharing agreements, if any) on line 457, column 7.

43. Enter total County Indigent Programs capitation premium revenue (Account 5980 - including settlements on risk sharing agreements, if any) on line 457, column 11.

44. Enter total Other Third Parties capitation premium revenue (Account 5990 - including settlements on risk sharing agreements, if any) on line 457, column 15.

45. Enter total capitation premium revenue (sum of 3, 7, 11, and 15) on line 457, column 23.

46. Enter the total net patient revenue on line 460 for each column, by subtracting total deductions from revenue on line 455 from total patient revenue on line 415 then adding capitation premium revenue on line 457.

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Page 14 SUPPLEMENTAL OTHER OPERATING REVENUE INFORMATION 7020.3

This page is used to report all Other Operating Revenue. Other Operating Revenue includes revenue from non-patient care services to patients, sales and activities by non-revenue producing cost centers to persons other than patients, rebates and refunds, expenditure abatements, transfers from restricted funds, and discounts on purchases. Please note that prior year cost report settlements are not to be included on this page. Such settlements are to be an adjustment to the current year contractual adjustments accounts and included on page 12.

This page is divided into four parts. Part I is for reporting cost reductions which affect several cost centers. Part II is to segregate minor recoveries which will be distributed to one cost center. Part III segregates other operating revenue for non-revenue producing centers of a larger amount than Parts I and II. Part III cost recoveries will be transferred to page 20, and offset during the cost allocation process, whereas the cost reductions and minor recoveries in Parts I and II will be offset against reclassified direct costs on pages 17 and 18. All restricted funds used for operations in non-revenue producing centers must be recorded as transfers and reported on line 185 of this page.

Part IV includes transfers from restricted funds for operation of revenue center activities, research, and medical education programs, as well as other educational revenue, such as, tuition and student housing income. These amounts are transferred to the cost allocation, page 20, line 445. All restricted funds used for operations in revenue-producing centers must be recorded as transfers and reported on line 270 of this page.

Non-operating revenue are not entered on this page. Such revenue, which includes property tax revenue collected by some governmental hospitals and cash discounts on purchases related to non- operating activities, are entered on the Statement of Income, page 8.1, column 1, lines 260 through 375.

Column 3 indicated the basis to distribute other operating revenue and column 2 identifies the page, column, and line to which the revenue are to be distributed. Be sure to follow this distribution precisely. It may be necessary to prepare worksheets for those line items which are distributed to more than one cost center. For instance, Cash Discounts on Purchases, Sale of Scrap and Waste, and Donated Commodities are to be distributed based on the supply costs in column 11, pages 17 and 18. If, however, any amount in Part I is specifically identifiable with a particular cost center, the amount must be distributed to that cost center.

1. Enter other operating revenue detail in column 1 from the general ledger accounts as indicated.

2. Additional cost reductions and minor recoveries can be listed on lines 35 through 50 and 95 through 115. You must specifically identify (up to 30 characters per line) all amounts included on these lines. Do not use "miscellaneous", "other", or "various" to describe these amounts. If additional line are needed, you may submit an

REPORTING REQUIREMENTS

attached worksheet specifying the additional items and related amounts.

3. Transfers from restricted funds for operations, Account 5790, for non-revenue producing centers are entered on line 185. Such transfers for revenue producing centers are entered on line 270.

4. Lines 200, 205, 210, and 215 are provided for other major cost recoveries related to non-revenue producing cost centers. You must specifically identify (up to 30 characters per line) all amounts on these lines. Do not use "miscellaneous", "other", or "various" to describe these amounts. If additional line are needed, you may submit an attached worksheet specifying the additional items and related amounts.

5. Subtotal lines 5 through 115 on line 120, lines 130 through 215 on line 220, and lines 225 through 270 on line 275. Total lines 120, 220, and 275 on line 280. The amount on line 280 must agree with the amount on page 8, column 1, line 135.

REPORTING REQUIREMENTS

Pages 15 and 16 RECLASSIFICATION WORKSHEET - PHYSICIAN AND STUDENT COMPENSATION 7020.4

Pages 15 and 16 are considered to be one form. Therefore, the subtotal amounts on both pages are totaled on page 16, line 305. These pages are used to segregate the compensation paid to students in teaching programs (exclusive of in-service education) and physicians among such items as research, education program activities (exclusive of in-service education), general hospital administration, patient care, and supervision and other cost center functions.

In addition, in order to obtain comparability of expenses, the physician and resident cost relative to patient care (professional component) must be isolated. The need for this is because all hospitals do not record the professional component as an expense; either because the physician does his own billing, or because such amounts are recorded in an agency account by the hospital.

The compensation of all physicians is to be included on this page, even those not involved in patient care.

The amounts in columns 1, 2 and 3 must be reclassified to the appropriate functional cost centers prior to being entered on the report pages 15 and 16. For reclassifications relative to physician and student compensation, the hospital can use a separate worksheet to reclassify the applicable amounts. These worksheets need not be submitted to the Office but must be maintained as a part of the hospital's records.

1. Enter in column 1 and 2 by cost center the salaries and wages and employee benefits, respectively relative to students participating in teaching programs (exclusive of in-service education) and to physicians. The physicians' salaries and wages would be in natural expense classification .07 on page 15. The students' salaries and wages would be included in natural expense classification .09 on page 16 (Medical Education accounts 8210 through 8290). The employee benefits would be included in natural expense classifications .10 through .19.

2. Enter the professional fees of the physicians (natural expense classification .20) by cost center in column 3.

3. It must be emphasized that any compensation and employee benefits included in columns 1, 2 and 3 of this page must not be included in pages 17 or 18, columns 1, 2, or 4.

4. Enter total compensation in column 4 the sum of columns 1 through 3.

5. Reclassify the total compensation paid to each physician and student by the proportionate amount of time spent by the physician or student in the major functions as listed in the headings of columns 5 through 10. A separate worksheet may be needed to accumulate the reclassified amounts related to the various functions. This worksheet must be maintained as a part of the hospital's records.

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Medicare rationales (the written allocation agreement between the hospital and the physician specifying how the physician spends his or her time) may be used as a starting place for determining allocation percentages. The following definitions relate to the compensation which will be reclassified:

Column 5 - Research being performed by individuals whose compensation is included in column 3. (Such costs will eventually be included in research on page 18).

Column 6 - Compensation paid to students who are involved in non-inservice educational activities in a classroom setting, and compensation paid to physicians who are functioning as educators of these students. (This portion of cost will eventually be included in education on page 18).

Column 7 - Amount paid to students and physicians for their participation in the general administration of the hospital or participation on various hospital committees. (This portion of student and physician compensation will eventually be included as other Administration Services on page 18).

Column 8 - Amount paid to nursing and paramedical students for care of hospital patients. (These costs will eventually be included in the cost centers on page 17).

Column 9 - Amounts paid to physicians, interns, and residents for the care of hospital patients. This patient care may be part of an educational program, but should be functionally classified in this column as opposed to column 5.

Column 10 - Amount paid to students and physicians for supervisory and other functions in their assigned cost center. This may include training activities of department staff. (This last portion of student and physician compensation will be included in each cost center on pages 17 and 18).

6. After allocation, the sum of the line amounts of columns 5, 6, 7, 8, 9, and 10 must equal the line amounts in column 4.

7. Enter on line 305, page 16, the total of lines 150, 225, and 405, page 15, and lines 10, 50 and 300, page 16.

8. Transfer to line 5, column 3, page 18, as Research Projects and Administration, the amount on line 305, column 5, page 16.

REPORTING REQUIREMENTS

9. Enter the education cost center amounts on lines 15 through 45, column 6, page 16, in the appropriate education cost centers on lines 15 through 45, column 3, page 18.

10. The sum of all other amounts in column 6, pages 15 and 16, are to be transferred to line 15, column 3, page 18, as Education Administrative Office. This amount can be determined by subtracting line 50, column 6, page 16 from line 305, column 6, page 16.

11. Enter the total General Administration costs from line 305, column 7, page 16, onto line 295, column 3, page 18, as Other Administrative Services.

12. Enter the Nursing and Paramedical Care of Hospital Patients individual line amounts in column 8, page 16 onto the appropriate lines on page 17, column 3. A separate schedule may be necessary to distribute amounts in column 8, page 16, to the revenue producing centers on page 17, column 3. Such distribution should be based upon the cost center assignment of the nursing and paramedical students.

13. Enter the Intern/Resident Care of Hospital Patients line amounts in column 9, lines 15 through 45, page 16, onto the appropriate lines in column 13, page 15. A separate schedule will be necessary to distribute amounts in column 9, page 16, to the revenue producing centers on page 15, column 13. Such distribution should be based upon the cost center assignments of the student, or the cost centers their specialties most closely support.

14. Enter the Supervision and Other Functions of the Cost Center line amounts in column 10, pages 15 and 16, onto the appropriate lines in column 3, pages 17 and 18.

Pages 17 and 18 TRIAL BALANCE WORKSHEETS AND SUPPLEMENTAL EXPENSE INFORMATION 7020.5

Pages 17 and 18 are considered to be one form. Therefore, the subtotal amounts on both pages are totaled on page 18, line 365.

These pages are used to report the direct expenses of every hospital cost center by natural classification of expense group, e.g., salaries and wages, employee benefits, professional fees, supplies, purchased services, depreciation, leases and rentals, and other direct expenses. The listing of cost centers includes non-operating cost centers on page 18, line 370. Expenses of non-operating cost centers, accounts 9020, 9030, 9510 through 9800 are entered on line 370, page 18, by natural classification of expense. Also, certain cost recoveries are applied to direct expenses on these pages. The number of standard units of measure for each non-revenue producing cost center on page 18 must be reported.

REPORTING REQUIREMENTS

PLEASE NOTE: The hospital must report expenses for every line (cost center) on these pages for which the hospital has incurred costs even though costs of certain functions are combined in the general ledger. For instance, various Fiscal Services cost centers may have been combined for accounting purposes, if there are justifiable reasons. However, for reporting purposes, these costs must be reclassified to meet the reporting requirements. (See page 7020.1 for more on reclassifications.)

DO NOT CHANGE THE COLUMN AND LINE LABELS. If a particular function or functions (such as Sleep Lab) does not fit, include such functions in the "Other" lines, e.g., Other Ancillary Services, Other General Services, and Other Administrative Services.

DO NOT NET NON-OPERATING REVENUE AGAINST NON-OPERATING EXPENSE. Only non-operating expenses are to be included on page 18, line 370.

All cost center reclassifications must be made prior to entering amounts on these pages. The actual amounts reclassified are netted figures of all the transactions affecting that particular cost center by natural expense classification.

1. Enter salaries and wages expense in column 1 (natural expense classification .00 through .06, .08, .09, .91 and .95. Exclude salaries of students (included in natural classification .09) from the medical education centers (page 18, column 1, lines 15 through 45). Physicians (.07) are excluded from all cost centers. Student and physician salaries and wages were entered on pages 15 and 16, column 1.

2. Enter in column 2 employee benefits (natural expense classification .10 through .19, .92 and .96), except those previously entered on pages 15 and 16, column 2, related to students and to salaried physicians. Employee Benefits (non-payroll related), Account 8880, on line 350 of page 18 includes only the non-payroll related employee benefits that were unassignable, since other employee benefits have already been charged to the various cost centers.

3. Column 3 amounts should have been previously entered from pages 15 and 16. If not, see the instructions for report pages 15 and 16, steps 5 through 11.

4. Enter in column 4 the total professional fees expense (natural classifications .21 through .29). Exclude medical - physicians fees (.20) as these were entered on pages 15 and 16, column 3.

5. Enter supplies expense in column 5 (natural classifications .31 through .50, .93, and .97).

6. Enter purchased services (natural classifications .61 through .69) in column 6.

REPORTING REQUIREMENTS

7. Enter straight-line depreciation expense in column 7 (natural classifications .71 through .74). Amounts in natural classifications .71 through .73 must be reported on line 305, page 18. Depreciation expense on equipment (.74) must be charged to and reported in the using cost centers.

8. Enter leases and rentals expense in column 8 (natural classifications .75 and .76). Leases and rentals expense on equipment (.76) must be charged to and reported in the using cost centers. Building leases and rentals expense (.75) must be reported on line 310, page 18.

9. Enter other direct expenses (natural classifications .77 through .90, .94 and .98) in column 9.

10. Enter the sum of columns 1 through 9 in column 10 for all lines on pages 17 and 18.

11. Enter in column 11 other operating revenue from page 14, lines 5 through 50, and 65 through 115 (Parts I and II) as adjustments of direct expenses.

    These adjustments are distributed in column 11 based on the instructions printed in columns 2 and 3 of page 14, and the following. All adjustments must be recorded as positive (unbracketed) amounts. It will be necessary to spread the cost adjustments identified in Part I, page 14, lines 5, 10, and 15, on a separate worksheet prior to entering them into column 11. Donated Commodities and the cost reductions related to Cash Discounts on Purchases and Sale of Scrap and Waste are allocated based on supply expenses, pages 17 and 18, column 5.

    CAUTION: Cash discounts on purchases and other cost recoveries are not to be allocated to non-operating expenses on page 18, line 370. Such revenue are to be recorded and reported as non-operating revenue on page 8.1.

12. The completion of column 12 is optional. The hospital may elect to have the Office do these calculations. If this column is affected by errors in previous portions of the report, the corrections to column 12 will be made automatically. If the hospital elects the Office to generate column 12, skip to step 14.

13. Subtract adjustments in column 11 from total direct expenses in column 10 and enter adjusted direct expenses in column 12.

14. The completion of page 17, column 13, is optional. If the hospital elects the Office to generate these data from page 4.1 and 4.2 for the hospital, skip to step 16.

REPORTING REQUIREMENTS

15. Units of service on page 17, column 13, lines 5 through 145 are to be entered from page 4.1, sum of columns 4 and 5. Units of service on page 17, column 13, lines 160 through 395 are to be entered from page 4.2, column 1.

16. Enter appropriate units of service on page 18, column 13. Please refer to the Statistical Cross Reference list on page 7020.5 and the cost center descriptions found in Chapter 2000. Do not record fractional or decimal units of service.

STATISTICAL CROSS REFERENCE LIST
FOR PAGE 18, COLUMN 13

	RESEARCH COSTS		
5	Research Projects and Administration	$1,000 of Gross Patient Revenue	= P.8, C.1, L.30÷1000
	EDUCATION COSTS		
15	Education Administrative Office	FTEs - Educational Programs Participants	≤ P.19, C.18, L.920
20	School of Nursing	Number of Full-Time Equivalent Students	≤ P.19,C.19,L.920
25	Licensed Vocational Nurse Program	Number of Full-Time Equivalent Students	≤ P.19, C.19, L.920
30	Medical Postgraduate Education	Number of Full-time Equivalent Students	= P.19, C.21, L.920
35	Paramedical Educational	Number of Full-Time Equivalent Students	≤ P.19, C.20, L.920
40	Student Housing	Number of Square Feet	= P.19, C.2, L.255
45	Other Health Profession Education	Number of Full-Time Equivalent Students	≤ P.19, C.20, L.920
	GENERAL SERVICES		
55	Printing and Duplicating	Number of Reams of Paper Used (500 sheets = Ream)	

REPORTING REQUIREMENTS

65	Non-Patient Food Service	Equivalent Number of Meals Served	
70	Dietary	Number of Patients Meals	= P.19, C.9, L.920
75	Laundry and Linen	Number of Dry and Clean Pounds Processed	> P.19, C.10, L.920
80	Social Work Services	Number of Personal Contacts	
90	Central Service and Supply	Number of Central Services and Supplies Adjusted Inpatient Days	= P.4.2, C.1, L.250
95	Pharmacy	Number of Pharmacy Adjusted Inpatient Days	= P.4.2, C.1, L.330
100	Purchasing and Stores	$1000 of Gross Non-Capitalized Purchases	≤ P.18, C.5, L.375÷1000
105	Grounds	Number of Square Feet of Ground Space	
110	Security	Number of Hospital FTE Employees	= (Σ P.21 + 22, C.24)÷2080
115	Parking	Number of Square Feet of Parking Area	
120	Housekeeping	Number of Square Feet Serviced	> P.19, C.7, L.920
125	Plant Operations	Number of Gross Square Feet	> P.19, C.2, L.920
130	Plant Maintenance	Number of Gross Square Feet	> P.19, C.2, L.920
135	Communications	Average Number of Hospital Employees	>(Σ P.21+22, C.24)÷2080
140	Data Processing	$1,000 of Gross Patient Revenue	= P.8, C.1, L.30÷1000
	FISCAL SERVICES		
155	General Accounting	Average Number of Hospital Employees	> (Σ P.21 + 22, C.24)÷2080
160	Patient Accounting	$1,000 of Gross Patient Revenue	= P.8, C.1, L.30÷1000

REPORTING REQUIREMENTS

165	Credit and Collection	$1,000 of Gross Patient Revenue	= P.8, C.1, L.30÷1000
170	Admitting	Number of Admissions	≈ P.4.1, C.12, L.150
175	Outpatient Registration	Number of Registrations	≤ P.4.2, C.1, L.560

ADMINISTRATIVE SERVICES

205	Hospital Administration	Number of Hospital FTE Employees	=(Σ P.21 + 22, C.24)÷2080
210	Governing Board Expense	$1,000 of Total Operating Revenue	=(P.8,C.1,L.30+L.135)÷1000
215	Public Relations	$1,000 of Total Operating Revenue	=(P.8,C.1,L.30+L.135)÷1000
220	Management Engineering	Number of Hospital FTE Employees	=(Σ P.21 + 22, C.24)÷2080
225	Personnel	Average Number of Hospital Employees	>(Σ P.21 + 22, C.24)÷2080
230	Employee Health Svcs.	Number of Hospital FTE Employees	=(Σ P.21 + 22, C.24)÷2080
235	Auxiliary Groups	Number of Volunteer Hours	
240	Chaplaincy Services	Number of Patient (Census) Days	= P.4.1,C.4+C.5,L.150
245	Medical Library	Number of Physicians on Active Staff	=P.1, C.1+2+3+4+5+6, L.320
250	Medical Records	Number of Adjusted Patient Days	=(P.12, C.23, L.415÷P.12, C.21, L.415) X (P.4.1, C.4+5, L.150)
255	Medical Staff Administration	Number of Physicians on Active Staff	= P.1, C1+2+3+4+5+6,L.320
260	Nursing Administration	Average Number of Nursing Service Personnel	>(Σ P.21,C.6+8+10 + P.21.1, C.2)÷2080
270	Inservice Education - Nursing	Number of Hours of Nursing Inservice Education	
275	Utilization Management	Number of Admissions	≈ P.4.1,C.12, L.150

REPORTING REQUIREMENTS

280	Community Health Education	Number of Participants

REPORTING REQUIREMENTS

UNASSIGNED COSTS

305	Depreciation and Amortization	Number of Gross Square Feet Owned	
310	Leases and Rentals	Number of Gross	Square Feet Leased
315	Insurance Hospital and Professional Malpractice	$1,000 of Gross Patient Revenue	= P.8, C.1, L30÷1000
320	Insurance - Other	Number of Gross	> P.19, C.2, L.920 Square Feet
325	Licenses and Taxes (other than on income)	Number of Gross Square Feet	> P.19, C.2, L.920
330	Interest - Working Capital	$1,000 of Gross Patient	= P.8, C.1, L.30÷1000 Revenue
345	Interest - Other	Number of Gross	> P.19, C.2, L.920 Square Feet
350	Employee Benefits (Non-Payroll)	Number of Hospital FTE Employees	=(Σ P.21 + 22, C.24)÷2080

$1,000 of Gross Patient Revenue = P.8, C.1, L.30÷1000. Appears on lines 5, 140, 160, 165, 315, and 330.

Gross Square Feet >P.19, C.2, L.920. Appears on lines 125, 130, 320, 325 and 345.

Number of Hospital FTEs = sum of P.21 + 22, C.24÷2080. Appears on lines 110, 205, 220, 230, and 350.

17. The completion of column 14 is optional. The hospital may elect to have the Office do these calculations. If this column is affected by errors in previous portions of the report, the corrections to column 14 will be made automatically. If the hospital elects the Office to generate column 14, skip to step 19.

18. Calculate the adjusted direct expense per unit of service to the second decimal by dividing column 12 by column 13 and enter the result in column 14.

19. For report periods ending on or before June 29, 2000, total page 17, lines 5 through 145 on line 150, lines 160 through 220 on line 225, lines 230 through 400 on line 405, and lines 150, 225, 405, and 410 on line 415.

REPORTING REQUIREMENTS

For report periods ending on or after June 30, 2000, total page 17, lines 5 through 145 on line 150, lines 160 through 220 on line 225, lines 230 through 400 on line 405, and lines 150, 225, 405, 410, and 411 on line 415.

20. Total page 18, line 5 on line 10; lines 15 through 45 on line 50; lines 55 through 145 on line 150; lines 155 through 195 on line 200; lines 205 through 295 on line 300, and lines 305 through 355 on line 360.

21. Enter on page 18, line 365, the sum of line 415, page 17, and lines 10, 50, 150, 200, 300 and 360, page 18.

22. Enter non-operating expenses on line 370. The total in column 11, line 370 must agree with the amount on page 8.1, column 1, line 425.

23. Total lines 365 and 370, page 18, on line 375.

24. The total direct operating costs on page 18, column 10, line 365 plus the Physicians' Professional Component on page 16, column 9, line 305 must equal the total operating expense on page 8, column 1, line 200.

25. The total cost recoveries on page 18, column 11, line 375 must agree with the amount on page 14, line 120.

Pages 21 AND 22 DETAIL OF DIRECT PAYROLL COSTS 7020.6

These two pages are used to report the productive hours and average hourly rate by employee classification by cost center. In addition, full-time equivalent employees are determined based on productive hours. The hours and average hourly rates reported on these pages must reflect reclassifications made to the cost center data reported on pages 17 and 18.

1. Enter the productive hours for each natural classification of salaries and wages by cost center in the appropriate columns 2, 4, 6, 8, 10, 12, 14, 16, 18, and 20. Productive hours equal total paid hours less hours not on the job. Hours not on the job include vacation time, sick time, holidays, and other paid time-off. Overtime pay and premium pay for "on-call" or "stand by" time must be included in salaries and wages.

   However, only actual hours worked must be included in productive hours. "On-call" time is not to be included in productive or non-productive hours. Calculate full-time salaried physicians as 40 hours per week each unless they have a definite schedule with identifiable hours, and actual hours are available. Report whole hours only. Labor hours related to capitalized labor costs should be excluded.

REPORTING REQUIREMENTS

2. Summarize total productive hours of all classifications for each cost center in column 22 by adding the amounts in the even numbered columns.

3. Enter total non-productive hours in column 23. (Do not include "on-call" time in non-productive hours).

4. Total columns 22 and 23 and enter total paid hours in column 24.

5. Subtotal columns 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 23 and 24 for lines 5 through 145, page 21, on line 150; lines 160 through 220, page 21, on line 225; lines 230 through 400, page 21, on line 405; line 5, page 22, on line 10; lines 15 through 45, page 22, on line 50; lines 55 through 145, page 22, on line 150; lines 155 through 195, page 22, on line 200; and lines 205 through 295, page 22, on line 300.

6. The completion of column 25 is optional. If the hospital elects the Office to calculate column 25, skip to step 8.

7. Divide the total productive hours in column 22 by 2080, and enter the resulting full-time equivalents, to the second decimal, in column 25. Use 2080 for both full and partial year reporting periods.

8. Compute the average hourly rate of pay to the second decimal for each natural classification of salary and wage expense (by cost center) and enter the amount in the appropriate column - 1, 3, 5, 7, 9, 11, 13, 15, 17, and 19. Average hourly rate of pay is computed by dividing total salaries and wages paid (productive dollars) by total productive hours.

9. The weighted average hourly rate for each group of cost centers and employee classification may be omitted at the hospital's option. The Office will calculate the weighted average if any of the following are left blank:

   Page 21, line 150 }
   Page 21, line 225 }
   Page 21, line 405 }
   Page 22, line 10 } odd columns only
   Page 22, line 50 }
   Page 22, line 150 }
   Page 22, line 200 }
   Page 22, line 300 }

   If the hospital elects the Office to complete the above lines, skip to step 11.

REPORTING REQUIREMENTS

10. Compute the weighted average hourly rate to the second decimal for each employee classification for each cost center group on lines 150, 225, and 405, page 21, columns 1, 3, 5, 7, 9, 11, 13, 15, 17 and 19 and lines 10, 50, 150, 200, and 300, page 22, columns 1, 3, 5, 7, 9, 11, 13, 15, 17 and 19. Weighted average hourly rate of pay is computed by dividing total salaries and wages paid (productive dollars) for each employee classification for each cost center group by the total productive hours for each employee classification of the cost center group.

11. Calculate the average hourly rate per cost center to the second decimal and enter the results in column 21. Average hourly rate is calculated for each cost center by dividing the total salaries and wages plus vacation pay, sick leave pay, holiday pay, and other time-off pay (subclassification of expense .12) by total paid hours in column 24, pages 21 and 22. The cost center average hourly rate must be computed for each cost center group on lines 150, 225 and 405, page 21 and lines 10, 50, 150, 200, and 300 on page 22.

12. On page 21, do not report data in column 13 and 14, since this employee classification (environment and food service) does not typically work in revenue producing cost centers.

13. On page 22, do not report data in columns 5 through 10 or columns 15 through 18, since these employee classifications must provide direct nursing or physician care to hospital patients and such care is not provided by or in non-revenue producing cost centers. For example, an RN functioning as an instructor must be reported as Technical and Specialist (.01), while a physician who is functioning as a manager must be reported as Management and Supervision (.00).

14. The following is provided as an example of the data needed and computations for completing these pages:

Example of computations for completing Report Pages 21 and 22

Employee A - Full-time Registered Nurse works in the Medical/ Surgical Acute Cost Center

Productive Dollars	
Regular Salaries and Wages	$13,920
Overtime Salaries and Wages @12 time	585
On-Call Premium	55
Total Salaries and Wages (Productive Dollars)	14,560
Non-Productive Dollars	
Vacation, Sick Leave, Holiday	1,680
Total Paid Dollars	$16,240

REPORTING REQUIREMENTS

Productive Hours	
Regular Hours	1,856
OT Hours	52
Total Productive Hours	1,908[1]
Non-Productive Hours	224
Total Paid Hours	2,132

Employee B - Part-time Ward Clerk works in Medical/ Surgical Acute Cost Center

Productive Dollars	
Regular Salaries and Wages	$ 3,640
Non-Productive Dollars	
Holidays	90
Total Paid Dollars	$ 3,730
Productive Hours	1,300[2]
Non-Productive Hours	32
Total Paid Hours	1,332

All Medical/Surgical Acute Cost Center Employees

Total Cost Center Productive Hours (1,908 + 1,300)	3,208[3]
Total Cost Center Non-Productive Hours (224 + 32)	256[4]
Total Cost Center Paid Hours (2,132 + 1,332)	3,464[5]
Total Cost Center Paid Dollars ($16,240 + $3,730)	$19,970

[1] Include these Hours on Page 21, Column 6, Line 45
[2] Include these Hours on Page 21, Column 12, Line 45
[3] Include these Hours on Page 21, Column 22, Line 45
[4] Include these Hours on Page 21, Column 23, Line 45
[5] Include these Hours on Page 21, Column 24, Line 45

Compute Medical/Surgical Acute "Registered Nurses" average hourly rate for Page 21, Column 5, Line 45, as follows:

Registered Nurses Total Productive Dollars)
Registered Nurses Total Productive Hours

$14,560/1,908 = $ 7.63

Compute Medical/Surgical Acute "Clerical and Other Administrative" average hourly rate for Page 21, Column 11, Line 45, as follows:

Clerical and Other Administrative Total Productive Dollars) Clerical and Other Administrative Total Productive Hours

$3,640/1,300 = $2.80

REPORTING REQUIREMENTS

Compute Medical/Surgical Acute Cost Center average hourly rate for Page 21, Column 21, Line 45, as follows:

Total Cost Center Paid Dollars)
Total Cost Center Paid Hours

$19,970/3,464 = $5.77

Compute Medical/Surgical Acute Full-Time Equivalent Employees for Page 21, Column 25, Line 45, as follows:

Cost Center Productive Hours) 2,080

3,208/2,080 = 1.54 FTE's

Pages 21.1 and 22.1 DETAIL OF DIRECT CONTRACTED COSTS 7020.7

These pages are used to report the cost and productive hours of registry nurses (natural classification .25) and other contracted services (natural classifications 21. and .26) such as accounting or clerical temporaries.

Complete these pages in a similar manner as pages 21 and 22.

1. On page 21.1, enter productive hours in columns 2 and 4 for each cost center. Enter total contracted hours (sum of columns 2 and 4) in column 5. Complete total lines 150, 225, and 405.

2. On page 22.1, enter productive hours in column 3 for each cost center. Complete total lines 10, 50, 150, 200, and 300.

3. Compute the average hourly rate of pay to the second decimal for each classification (by cost center) and enter the result in column 1 and 3, as appropriate. These rates are computed by dividing total dollars by productive hours. Total dollars must agree to natural classifications .21, .25 and .26 in the hospital's general ledger.

4. The weighted average hourly rate for each group of cost centers and classifications may be omitted at the hospital's option. The Office will calculate the weighted average if columns 1 and 3 are left blank for the following:

   Page 21.1, line 150
   Page 21.1, line 225
   Page 21.1, line 405
   Page 22.1, line 10
   Page 22.1, line 50
   Page 22.1, line 150
   Page 22.1, line 200
   Page 22.1, line 300

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5. Compute the weighted average hourly rate to the second decimal for each classification for each cost center group on lines 150, 225, and 405, page 21.1, columns 1 and 3, and lines 10, 50, 150, 200, and 300, page 22.1, column 1. Weighted average hourly rate of pay is computed by dividing total dollars for each classification for each cost center group by the total productive hours for each classification of the cost center group.

Page 19a COST ALLOCATION - STATISTICAL BASIS SHORT FORM 7020.8

Pages 19 and 20 are used to perform the cost allocation. However, hospitals may elect to file either the full cost allocation (pages 19 and 20) or a "streamlined" cost allocation (pages 19a and 20a). The streamlined reporting option requires the completion of only those columns and lines that are necessary for the Office to perform the cost allocation. The optional data fields will be completed by the Office using data from other report pages. Those hospitals electing to file a "streamlined" cost allocation, or pages 19a and 20a, must follow the instructions specified in Instruction No. 1. below. Full cost allocation is accomplished by filing completed pages 19 and 20 as indicated in Instruction No. 2, which are located in Section 7020.10 of the Manual. Under this option, pages 19a and 20a are not completed.

Instruction No. 1

These instructions are to be followed only by those hospitals which have elected the Office to complete the full cost allocation and are therefore filing pages 19a and 20a in lieu of pages 19 and 20. The instructions for completing page 20a are located in Section 7020.9 of the Manual.

1. Enter square feet occupied by each cost center in column 2. Square feet occupied excludes common and unused areas and is computed as specified in Section 5032. Foot the column and enter the total on line 920.

2. Enter in column 7 square feet serviced by the Housekeeping cost center during the reporting period. These figures should be equal to or less than the square feet occupied figures recorded in column 2. Do not enter percentages.

3. Enter the number of meals served to patients during the reporting period in column 9, lines 505 through 645, 660, 670, 685 through 715, 845 and 890. Total meals served on line 920, column 9 must equal page 18, column 13, line 70.

4. Enter dry and clean pounds of laundry processed during the reporting period (including equivalent pounds for disposable linen) in column 10. (Please note that since Housekeeping and Dietary will have already been distributed, there will be no assignment of laundry and linen cost to those and other centers already distributed.) Do not enter percentages. The actual number of pounds for the reporting period must be specified.

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5. Enter in column 14 the dollar total of costed central supply requisitions (based on invoice/inventory cost). These are the dollars of nonchargeable patient supplies transferred to the using cost centers from Central Services and Supplies. The lines to be completed would be those remaining cost centers which received the transferred supply cost.

   On line 750, column 14, enter the cost of sales (patient chargeables only) from page 17, column 10, line 250.

6. Enter in column 15 the dollar total of costed pharmacy requisitions (based on invoice/inventory cost). These are the dollars of nonchargeable pharmaceuticals transferred to the using cost centers from Pharmacy. The lines to be completed would be those remaining cost centers which received the transferred pharmaceuticals cost.

   On line 830, column 15, enter the cost of sales (patient chargeables only) from page 17, column 10, line 330.

7. Enter in column 18 the number of students in all non-inservice education programs administered by the Education Administration Office in their respective cost center within the medical education group, lines 260 through 280.

8. Enter in column 19 the number of full-time equivalent RN and LVN nursing students in non-inservice education programs by the cost center(s) to which they were assigned for training. FTEs are defined as the number of paid nursing student months divided by 12, calculated to two decimal places. (Enter zeros if necessary.) Partial months are counted as one when one half or more of the month is worked and not counted when less than half of the month is worked.

9. Enter in column 20 the number of full-time equivalent paramedical non-nursing students by the cost center(s) to which they were assigned during training. FTEs are defined as the number of paid paramedical student months divided by 12, calculated to two decimal places. (Enter zeros if necessary.) Partial months are counted as one when one half or more of the month is worked and not counted when less than half of the month is worked.

10. Enter in column 21 the number of full-time equivalent (FTE) postgraduate medical education students in both approved and non-approved programs by the cost center to which they were assigned during training. FTEs are defined as the number of paid residency/fellowship months divided by 12, calculated to two decimal places. (Enter zeros if necessary.) Partial months are counted as one when one half or more of the month is worked and not counted when less than half of the month is worked.

11. Foot all columns and enter the results on line 920.

REPORTING REQUIREMENTS

Page 20a COST ALLOCATION SHORT FORM 7020.9

Hospitals electing to have the Office complete the cost allocation must complete page 20a. This is in lieu of completing page 20. Hospitals which completed page 20 should skip to Section 7020.11.

Columns 1 through 6, page 20a, are used to provide information on the assignment of certain Other Operating Revenue items to appropriate non-revenue producing centers. Column 7 is used to provide information on the assignment of restricted funds which were transferred to the unrestricted fund to offset operating costs incurred by revenue producing cost centers. This information will be used in conjunction with page 19 to computer-produce the cost allocation.

1. Enter on line 1, column 1, the Transfers for Operations (Non-Revenue Producing Centers) from page 14, line 185.

2. Enter on line 1, columns 2, 3, 4, and 5, the Other Operating Revenue from page 14, column 1, lines 200, 205, 210 and 215, respectively.

3. Enter on line 1, column 6, the Transfers from Restricted Funds for Education revenue from page 14, line 260.

4. The cost recovery amounts on line 1, columns 1 through 6, are to be offset against the related operating costs incurred by non-revenue producing cost centers during the cost allocation process. Therefore, for columns 1, through 6, enter on lines 5 through 280 the applicable amount of the Other Operating Revenue entered on line 1 to be offset against the various cost centers. For example, if the restricted funds amount entered on line 1, column 1 was to offset accounting and data processing costs related to a grant project, the appropriate amounts would be entered on lines 65 and 160, column 1.

5. No figures are to be entered in shaded areas and the total of lines 1 through 280, columns 1 through 6, must equal zero.

6. Enter on line 500, column 7, the Transfers for Operations (Revenue Producing Centers) from page 14, line 270, column 1. Enter the appropriate amounts of line 500, column 7, in the appropriate cost centers in column 7, lines 505 through 900, on the basis of the transfers to the unrestricted fund, (e.g. as restricted). The donor's or grantor's restrictions will help to identify the cost center(s) to which the transfers are applicable.

7. Total column 7, lines 505 through 645 and enter the result on line 650.

8. Total column 7, lines 660 through 720 and enter the result on line 725.

9. Total column 7, lines 730 through 900 and enter the result on line 905.

10. The sum of lines 500, 650, 725, and 905 must equal zero.

REPORTING REQUIREMENTS

Pages 19 and 20 COST ALLOCATION - STATISTICAL BASIS AND COST ALLOCATION 7020.10

Page 20 provides for the allocation of the expenses of each non-revenue producing cost center to those cost centers which receive service. After the final allocation, all non-revenue producing cost center costs have been allocated to the revenue-producing and non-operating cost centers. Certain Other Operating Revenues (cost recoveries) are offset during cost allocation, and certain other cost recoveries are offset after cost allocation. This treatment of cost recoveries is required.

Page 19 provides the statistical data needed to allocate the expenses of the non-revenue producing cost centers to the revenue producing, non-revenue producing, and non-operating cost centers. See Section 5032 for definitions or methods of computation of the cost allocation statistics.

Hospitals may file either the full cost allocation or a "streamlined" cost allocation. Streamlined reporting is accomplished by filing pages 19a and 20a, as indicated in Instruction No. 1. Full cost allocation is accomplished by filing completed pages 19 and 20, as indicated in Instruction No. 2, in which case pages 19a and 20a are not completed. Those hospitals electing to file a "streamlined" cost allocation should proceed to Instruction No. 1.

Instruction No. 2

The column numbers are identical for both pages 19 and 20. The statistical bases shown at the top of each column are the required bases of allocation of the lines indicated. For example, in column 2 the required basis of allocation for lines 5 through 25 is square feet. The cost centers must be allocated on the bases specified unless prior written approval has been granted by the Office.

In some cases, the basis of allocation is repeated in a later column (e.g., square feet). When this occurs the total statistical base over which the costs are to be allocated will differ because of the elimination of cost centers that have been closed.

The cost centers must be allocated in the same order specified by pages 19 and 20.

Cost recoveries must be offset in the column specified by the directions on page 14 and by the placement of the lines in the columns on page 20 (lines 350 through 445). If the cost recoveries are in excess of the cost to be allocated, the credit amount will be allocated in the normal manner.

Because of the close relationship between pages 19 and 20, the following instructions apply to both pages. Appropriate page references have been indicated.

NOTE: The Medical Supplies Sold to Patients cost center on line 750, page 20, is not to receive allocation in columns 2 and 4 through 13. The Central Services and Supplies cost center on line 235, page 20, is to receive allocation in all columns, as appropriate, until that line is allocated in column 14. Therefore, no allocation statistics are to be entered on line 750 page 19, columns 2 and 4 through 13. Line 750, page 19, and line 750, page 20, have been shaded appropriately.

REPORTING REQUIREMENTS

NOTE: The Drugs Sold to Patients cost center on line 830, page 20, is not to receive allocation in columns 2, 5, and 7 through 14. The Pharmacy cost center on line 240, page 20, is to receive allocation in all columns, as appropriate, until that line is allocated in column 15. Therefore, no allocation statistics are to be entered on line 830, columns 2, 5, and 7 through 14, page 19. Line 830, page 19 and line 830, page 20, have been shaded appropriately.

1. Enter on page 20, column 1, in lines, as appropriate, the adjusted direct expenses from pages 17 and 18, column 12. The line numbers for revenue-producing cost centers on page 20 are 500 greater than on page 17. For example, Medical/Surgical Intensive Care line number on page 17 is 5 and on page 20 it is 505.

2. Adjusted direct expenses for non-operating cost centers are entered from page 18, column 12, line 370 on page 20, column 1, line 915.

3. Enter cost recoveries from page 14, Part III, lines 130 through 215, on page 20, column 1, lines 350 through 435. These cost recoveries are also to be reentered on an individual line basis as unbracketed figures in the column in which the cost center which generated this revenue is being allocated as designated by page 14, column 2, and as dictated by the line placement in the columns on page 20. Although typically each line item cost recovery is reentered in only one column, in the case of transfers from restricted funds for operations (non-revenue centers), line 415, and Other Operating Revenue lines 420, 425, 430, and 435, there may be several columns involved. (See items 6 and 7 below).

4. The restricted fund transfers for operations (non-revenue centers) on page 20, line 415, are not to be entered into column 22, which is reserved for those restricted fund transfers for operations relating to revenue centers, but are to be entered in the column to which the transfer relates. The donors' restrictions will help identify the non-revenue producing cost center(s) for which the transfers for operations are applicable.

5. The other operating revenue, page 20, lines 420, 425, 430, and 435, is to be entered in the column or columns in which the cost center to which the revenue relates is being allocated.

6. Enter on page 20, line 445, column 1, (and other columns as designated by page 14, column 2) transfers from restricted funds for research, education, and for operations (revenue centers), and education revenue from page 14 (Part IV), or the total from page 14, line 275. Transfers for operations (revenue centers) from page 14, line 270, are entered in column 22 of page 20. The amounts on lines 225 through 255, page 14 are entered in columns 17 through 21 as required by the distribution instructions on page 14, and line 260, Transfer from Restricted Funds for Education, is entered in columns 18 through 21 as appropriate.

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7. Enter the total of lines 5 through 280, column 1, page 20, on line 285.

8. Enter the total of lines 350 through 435, column 1, page 20, on line 440.

9. Enter the total of lines 505 through 645, column 1, page 20, on line 650.

10. Enter the total of lines 660 through 720, column 1, page 20, on line 725.

11. Enter the total of lines 730 through 900 column 1, page 20, on line 905.

12. For report periods ending on or before June 29, 2000, enter on line 920, column 1, page 20, the total of lines 285, 440, 445, 650, 725, 905, 910, and 915, column 1. For report periods ending on or after June 30, 2000, enter on line 920, column 1, page 20, the total of lines 285, 440, 445, 650, 725, 905, and 915, column 1. In both cases, this total should equal the total of page 8, column 1, line 200, minus page 14, column 1, line 280 (Other Operating Revenue), minus page 16, column 9, line 305 (Physician and Intern/Resident Care of Hospital Patients), and plus page 18, column 12, line 370.

13. Total page 20, lines 350 through 435, columns 2, 4 through 15, and 17 through 21, and enter the results on line 440, column as appropriate.

14. Enter square feet occupied by each cost center in column 2, page 19. Square feet occupied excludes common and unused areas and is computed as specified in Section 5032. Foot the column and enter the total on line 920.

15. The first allocation follows and it typifies the process of allocating the non-revenue producing centers:

    Total lines 5 through 25, column 1, page 20, and enter the sum on line 25, column 2, page 20, as a bracketed figure. Transfer the amount on page 20, line 25, column 2, to page 19, column 2, line 925 as an unbracketed figure. Transfer the total cost recoveries from lines 440 and 445, column 2, page 20, to page 19, column 2, line 930. Subtract on page 19, column 2, line 930 from line 925, and enter net cost on line 935.

    Calculate the unit multiplier to at least seven decimals by dividing line 935 by line 920. Enter the unit multiplier to three decimals on line 940, column 2. Multiply the seven decimal place unit

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multiplier times each cost center's square feet occupied which has been entered in column 2, lines 35 through 915 on page 19. Enter the results on corresponding lines on page 20, column 2. Total page 20, column 2, lines 505 through 645 on line 650, total lines 660 through 720 on line 725, and total lines 730 through 900 on line 905. For report periods ending on or before June 29, 2000, total page 20, column 2, lines 25 through 280, 440, 635, 905 440, 445, 650, 725, 905, 910 and 915 and enter the result on line 920. For report periods ending on or after June 30, 2000, total page 20, column 2, lines 25 through 280, 440, 635, 905 440, 445, 650, 725, 905, and 915 and enter the result on line 920.The total must be zero because the first figure of the column is bracketed and all other figures in the column are unbracketed.

NOTE: The total on line 920 in columns 2, 4 through 15, and 17 through 22 must be zero. It may be necessary due to rounding to adjust the allocated amounts in order that the total on line 920 for these columns will equal zero. When adjusting the allocation, do not adjust only one item, as this will distort the allocation. Instead, adjust those items on which the adjustment will have the least affect percentage-wise.

16. Subtotal columns 1 and 2, page 20, to column 3 to identify the total accumulated costs in the surviving cost centers at that point in the allocation process. For report periods ending on or before June 29, 2000, column 3 amounts are calculated by adding the adjusted direct costs from column 1 to the allocated costs in column 2 for lines 30 through 280, lines 350 through 435, 445, 505 through 645, 660 through 720, 730 through 900, 910, and 915. For report periods ending on or after June 30, 2000, column 3 amounts are calculated by adding the adjusted direct costs from column 1 to the allocated costs in column 2 for lines 30 through 280, lines 350 through 435, 445, 505 through 645, 660 through 720, 730 through 900, and 915.

17. Subtotal column 3, page 20, lines 30 through 280 on line 285, lines 350 through 435 on line 440 lines 505 through 645 on line 650, lines 660 through 720 on line 725, and lines 730 through 900 on line 905. For report periods ending on or before June 29, 2000, determine the final total by adding lines 285, 440, 445, 650, 725, 905, 910, and 915. For report periods ending on or after June 30, 2000, determine the final total by adding lines 285, 440, 445, 650, 725, 905, and 915. In both cases, enter the result on line 920 for column 3.

18. Transfer accumulated cost figures from column 3, page 20, lines 85 through 280, and lines 505 through 645 and 660 through 720, and lines 730 through 900 to the appropriate lines, page 19, column 4. Line 915 page 20, column 3, would be transferred to

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page 19, column 4, line 915 only if the non-operating cost centers should absorb the overhead being allocated in column 4.

19. Enter in column 5, page 19, the hospital full-time equivalent data computed on pages 21 and 22, column 25. FTE's must be recorded to two decimal places. (Enter zeros if necessary.)

20. Enter in column 6, page 19, supply costs from pages 17 and 18, column 5. The amounts on pages 17 and 18, column 5, represent direct costs for supplies.

21. Enter in column 7, page 19, square feet serviced by the Housekeeping cost center during the reporting period. These figures should be equal to or less than the figures recorded in column 2. Do not enter percentages.

22. Transfer square feet occupied from page 19, column 2 to page 19, column 8 for all remaining (open) cost centers.

23. Enter the number of meals served to patients during the reporting period in column 9, page 19, lines 505 through 645, 660, 670, 685 through 715, 845 and 890. Total meals served on line 920, column 9, must equal page 18, column 13, line 70.

24. Enter the number of dry and clean pounds of laundry processed during the reporting period (including equivalent pounds for disposable linen) in column 10, page 19. (Please note that since Housekeeping and Dietary have already been distributed, there will be no assignment of laundry and linen costs to those and other centers already distributed). Do not enter percentages. The actual number of pounds must be specified.

25. Enter gross patient revenue from page 12, column 23, in column 11, page 19, lines as appropriate. Medical Supplies Sold to Patients and Drugs Sold to Patients revenue must be recorded on lines 235 and 240, respectively, rather than on lines 750 and 830.

26. Enter gross outpatient revenue from page 12, column 22, in column 12, page 19, lines as appropriate. Medical Supplies Sold to Patients and Drugs Sold to Patients revenue must be recorded on lines 235 and 240, respectively, rather than on lines 750 and 830.

27. Enter in column 13, page 19, nursing full-time equivalents. To determine FTEs, divide total productive hours, from page 21, columns 6, 8, and 10, and page 21.1, column 2, by 2080. FTEs must be recorded to two decimal places (enter zeros if necessary).

28. Enter on page 19, column 14, the dollar total of costed central supply requisitions (based on invoice/inventory cost). These are the dollars of non-chargeable patient supplies transferred to the

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using cost centers from Central Services and Supplies. The lines to be completed would be those remaining cost centers which received the transferred supply cost.

On line 750, column 14, page 19, enter the cost of sales (patient chargeables only) from page 20, column 1, line 750.

29. Enter in column 15, page 19, the dollar total of costed pharmacy requisitions (based on invoice/inventory cost). These are the dollars of non-chargeable pharmaceuticals transferred to the using cost centers from Pharmacy. The lines to be completed would be those remaining cost centers which received the transferred pharmaceutical cost.

    On line 830, column 15, page 19, enter the cost of sales (patient chargeables only) from page 20, column 1, line 830.

30. If there are any research costs accumulated on lines 250 through 280, page 20, column 16, transfer gross patient revenue from page 19, column 11, to page 19, column 17. Drugs Sold to Patients and Medical Supplies Sold to Patients revenue should now be recorded on lines 750 and 830. Do not enter purchased Inpatient Services revenue from column 11, line 910, in column 17.

31. Enter in page 19, column 18, the number of students in all non-inservice education programs administered by the Education Administration Office in their respective cost center within the medical education group, lines 260 through 280.

32. Enter in page 19, column 19, the number of full-time equivalent (FTE) RN and LVN nursing students in non- inservice education programs by the cost center(s) to which they were assigned for training. FTEs are defined as the number of paid nursing student months divided by 12. Calculate to two decimal places. (Enter zeros if necessary.) Partial months are counted as one when one-half or more of the month is worked and not counted when less than half of the month is worked.

33. Enter in page 19, column 20, the number of full-time equivalent paramedical non-nursing students by the cost center(s) to which they were assigned during training. FTEs are defined as the number of paid paramedical student months divided by 12. Calculate to two decimal places. (Enter zeros if necessary.) Partial months are counted as one when one-half or more of the month is worked and not counted when less than half of the month is worked.

34. Enter in page 19, column 21, the number of full-time equivalent (FTE) postgraduate medical education students in both approved

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and non-approved programs by the cost center(s) to which they were assigned during training. FTEs are defined as the number of paid residency/fellowship months divided by 12. Calculate to two decimal places. (Enter zeros if necessary.) Partial months are counted as one when one-half or more of the month is worked and not counted when less than half of the month is worked.

35. Complete footing on line 920 as appropriate.

36. Repeat the allocation process for columns 4 through 15 as typified in step 16. The amount allocated in each column, page 20, is the sum of those lines indicated in the column heading in all columns (except columns 1 and 2) preceding the column being allocated. For example, the amount to be entered on line 140, column 8, page 20, would be the sum of the amounts on lines 115 through 140, column 3 through column 7.

37. After column 15, page 20, has been completed, subtotal the remaining lines, columns 3 through 15 and enter the results in column 16, page 20, to identify the total accumulated costs in the surviving cost centers at that point in the allocation process.

38. Continue the allocation process for columns 17 through 21. Since the allocated costs have been subtotaled in column 16, the amounts to be allocated for columns 17 through 21 are summarized from, and including, column 16.

39. On line 445, column 22, page 20, is the amount of transfers from restricted funds for operating costs for revenue-producing centers. Column 22 is used to offset such transferred funds against the related costs. Enter such transfers in the appropriate cost centers in column 22, lines 505 through 900, on the basis of the transfers to the unrestricted fund, (i.e., as restricted).

40. Total columns 16 through 22, lines 505 through 915, page 20, and enter the results in column 23.

41. Complete footings as appropriate. The totals on page 20, line 920, columns 1, 3, 16, and 23 must be equal.

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Page 8.1 STATEMENT OF INCOME - UNRESTRICTED FUND (NON-OPERATING REVENUE AND EXPENSE) 7020.11

This page is used to report the non-operating revenue and expense of the hospital for report periods ending on or before June 29, 2000. The total net non-operating revenue and expense from this page is reported on page 8 of the report. The total non-operating expense from this page is reported on page 18 of the report. For report periods ending on or after June 30, 2000, this page has been combined with report page 8 (See Instruction No. 2 in Manual Section 7020.12)

The prior year column (column 2) is optional if all data items are the same as reported on the previous year's report (column 1). If there has been a restatement or adjustment since the previous report was filed, the prior year column must be completed.

1. Enter gains on sale of hospital property (Account 9010) on line 260.

2. Enter maintenance of restricted funds revenue (Account 9030) on line 265.

3. Enter unrestricted contributions (Account 9040) on line 270.

4. Enter donated services (Account 9050) on line 275.

5. Enter income, gains and losses from unrestricted investments (Account 9060) on line 280. Include all unrestricted non-patient interest income.

6. Enter unrestricted income from endowment funds (Account 9070) on line 285.

7. Enter unrestricted income from other restricted funds (Account 9080) on line 290.

8. Enter term endowment funds becoming unrestricted (Account 9090) on line 295.

9. Enter transfers from restricted funds for non-operating expenses (Account 9100) on line 300.

10. District hospitals enter assessment revenue (Account 9150), county allocation of tax revenue (Account 9160), special district augmentation revenue (Account 9170), debt service tax revenue (Account 9180), and State Homeowner's Property Tax Relief (Account 9190) on lines 305, 310, 315, 320 and 325, respectively.

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11. State and district hospitals only enter on line 330 the amount appropriated from the State General Fund (Account 9200) or other State sources for operating deficits or other operating needs. The amount reported should not exceed the actual amount of the appropriation(s) expended and/or encumbered.

12. County hospitals enter on lines 335, 340 and 345, the amount appropriated from the County General Fund or other sources for operating deficits or other operating needs. Enter on line 335 the amount of Realignment funds unrelated to direct patient care (Account 9210) provided to the hospital. See Section 1280 of the Manual for more information on Realignment Funds. Enter on line 340 the amounts of County General Funds provided (Account 9220). Enter on line 345 the amount of Other Funds (Account 9230) provided by the County. The amounts reported should not exceed the actual amount of the appropriations(s) expended and/or encumbered. If a County hospital repays the County any portion of the County appropriations(s), the repayment must be abated against current year appropriations.

13. Enter physicians' offices and other rentals revenue (Account 9250) on line 350.

14. Enter on line 355 medical office building revenue (Account 9260).

15. Enter on line 360 child care service revenue (non-employees) (Account 9270).

16. Enter on line 365 family housing revenue (Account 9280).

17. Enter retail operations revenue (Account 9290) on line 370.

18. Enter other non-operating revenue (Account 9400) on line 375.

19. Total lines 260 through 375 and enter the resulting total non-operating revenue on line 380.

20. Enter losses on sale of hospital property (Account 9020) on line 385.

21. Enter maintenance of restricted funds expenses (Account 9030) on line 390.

22. Enter physicians' offices and other rentals expenses (Account 9510) on line 395.

23. Enter on line 400 medical office building expense (Account 9520).

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24. Enter on line 405 child care service expense (Non-Employees) (Account 9530).

25. Enter on line 410 family housing expense (Account 9540).

26. Enter retail operations expenses (Account 9550) on line 415.

27. Enter other non-operating expenses (Account 9800) on line 420.

28. Total lines 385 through 420 and enter the resulting total non-operating expenses on line 425. This amount must agree with page 18, column 10, line 370.

29. Subtract line 425 from line 380 and enter net non-operating revenue and expenses on line 430. Transfer this total to page 8, line 210.

30. District hospitals enter on line 435 the amount of interest expense on long-term debt included on page 8, line 180.

Page 8 STATEMENT OF INCOME - UNRESTRICTED FUND 7020.12

This page is used to report the revenue and expenses of the hospital for the reporting period. Although this report could be developed from the general ledger accounts, for the most part this report is completed by using data contained in previously completed report pages.

Enter current year data in column 1. Enter prior year data in column 2 from the previous year's report.

The prior year column (column 2) is optional if all data items are the same as reported on the previous year's report (column 1). If there has been a restatement or adjustment since the previous report was filed, the prior year column must be completed. If column 2 is completed, submit a brief explanatory statement as to what these differences are and the reasons for them as an attachment to the certification required by Manual Section 7020.24.

For report periods ending on or before June 29, 2000, complete report page 8 following the instructions specified in Instruction No. 1. For report periods ending on or after June 30, 2000, complete report page 12 following the instructions specified in Instruction No. 2.

Instruction No. 1 (Report Periods ending on or before June 29, 2000)

1. Enter in column 1, line 5, the total daily hospital services gross revenue from page 12, column 25, line 150.

2. Enter on line 10, the total ambulatory services gross revenue from page 12, column 25, line 225.

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3. Enter on line 15, the total ancillary services gross revenue from page 12, column 25, line 405.

4. Enter on line 20 the total purchased inpatient services gross revenue from page 12, column 25, line 410.

5. Total lines 5, 10, 15 and 20, on line 30. This total gross patient revenue must agree with the gross patient revenue on page 12, column 25 line 415.

6. Enter provisions for bad debts (Account 5800) on line 35. This is the amount of gross revenue which will not be paid by those unwilling to pay. Do not enter on this line amounts related to medically indigent patients (i.e., patients with an inability to pay). Such amounts must be recorded as charity discounts.

7. Enter Medicare contractual adjustments (Account 5810) on line 40.

8. Enter Medi-Cal contractual adjustments (Account 5820) on line 45 and Medi-Cal disproportionate share payments (Account 5821) on line 46. Be sure that disproportionate share payments reported on line 46 are not also included on line 45.

9. Enter County Indigent Programs contractual adjustments (Account 5830) on line 50.

10. Enter HMO/PPO and Other Contracts contractual adjustments (Account 5840) on line 55. Report capitation premium revenue separately on line 56.

11. Enter Capitation Premium Revenue (Account 5841) on line 56.

12. Enter other contractual adjustments (Account 5850) on line 60.

13. Enter Hill-Burton Charity Discounts (Account 5860) on line 65 and Other Charity Discounts (Account 5870) on line 70. See Section 1400 for the definition of Charity Care.

14. Enter restricted donations and subsidies for indigent care (Account 5880) on line 75.

15. Only University of California teaching hospitals are to complete lines 80 and 85. Enter Support for Clinical Teaching (Account 5910) and Teaching Allowances (Account 5890) on lines 80 and 85, respectively.

16. Enter policy discounts (account 5970) administrative adjustments (Account 5980), and other deductions from revenue (Account 5990) on lines 90, 95, and 100, respectively.

17. Sum deductions from revenue amounts, lines 35 through 100, and

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enter the total on line 105. This total must agree with page 12, column 25, line 455.

18. Subtract deductions from revenue on line 105 from gross patient revenue on line 30 and enter the resulting net patient revenue on line 110. The figure on line 110 must equal page 12, column 25, line 460.

19. Enter on line 135 total other operating revenue from page 14, column 1, line 280.

20. Add net patient revenue and total other operating revenue on lines 110 and 135, and enter the resulting total operating revenue on line 140.

21. Enter on line 145 total salaries and wages expense from page 18, column 1, line 365 and page 15, column 1, line 305.

22. Enter on line 150 total employee benefits expense from page 18, column 2, line 365, and page 16, column 2, line 305.

23. Enter on line 155 the total professional fees expense from page 18, column 4, line 365 and page 16, column 3, line 305.

24. Enter on line 160 total supplies expense from page 18, column 5, line 365.

25. Enter on line 165 total purchased services from page 18, column 6, line 365.

26. Enter on line 170 total depreciation expense from page 18, column 7, line 365.

27. Enter on line 175 total leases and rentals expense from page 18, column 8, line 365.

28. Enter on line 180 total Interest expense from page 18, column 9, line 330 plus line 345.

29. Enter on line 185 all other direct expenses from page 18, column 9, line 365 minus lines 330 and 345.

30. Total lines 145 through 185 and enter the result on line 200. Line 200 must agree with page 18, column 10, line 365 plus page 16, column 9, line 305.

31. Subtract total operating expense line 200 from total operating revenue line 140 and enter net from operations on line 205.

32. Enter on line 210 the net non-operating revenue from page 8.1, line 430.

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33. Total lines 205 and 210 and enter the resulting net income before taxes and extraordinary items on line 215.

34. Enter current provision for income taxes (Accounts 9901 and 9903 on line 220).

35. Enter deferred provision for income taxes (Accounts 9902 and 9904 on line 225).

36. Subtract lines 220 and 225 from line 215 and enter the resulting net income before extraordinary items on line 230).

37. Enter extraordinary items (Account 9920 on lines 235 and 240 Provide a brief description (up to 50 characters) of each item. Enter extraordinary income amounts as negative (bracketed) figures.

38. Subtract lines 235 and 240 from line 230 and enter the resulting net income (loss) on line 245.

Instruction No. 2 (Report Periods ending on or after June 30, 2000)

1. Enter in column 1, line 5, the total daily hospital services gross revenue from page 12, column 23, line 150.

2. Enter on line 10, the total ambulatory services gross revenue from page 12, column 23, line 225.

3. Enter on line 15, the total ancillary services gross revenue from page 12, column 23, line 405.

4. Total lines 5, 10, and 15 on line 30. This total gross patient revenue must agree with the gross patient revenue on page 12, column 23 line 415.

5. Go to line 300. Enter provisions for bad debts (Account 5800) on line 300. This is the amount of gross revenue which will not be paid by those unwilling to pay. Do not enter on this line amounts related to medically indigent patients (i.e., patients with an inability to pay). Such amounts must be recorded as charity discounts.

6. Enter Medicare - Traditional contractual adjustments (Account 5811) on line 305.

7. Enter Medicare - Managed Care contractual adjustments (Account 5812) on line 310.

8. Enter Medi-Cal -Traditional contractual adjustments (Account 5821) on line 315 and Medi-Cal disproportionate share payments (Account 5830) on line 325. Be sure that disproportionate share payments reported on line 325 are not also included on line 315.

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9. Enter Medi-Cal - Managed Care contractual adjustments (Account 5822) on line 320.

10. Enter County Indigent Programs -Traditional contractual adjustments (Account 5841) on line 330.

11. Enter County Indigent Programs - Managed Care contractual adjustments (Account 5842) on line 335.

12. Enter Other Third Parties - Traditional contractual adjustments (Account 5851) on line 340.

13. Enter Other Third Parties - Managed Care contractual adjustments (Account 5852) on line 345.

14. Enter Hill-Burton Charity Discounts (Account 5860) on line 350 and Other Charity Discounts (Account 5870) on line 355. See Section 1400 for the definition of Charity Care.

15. Enter restricted donations and subsidies for indigent care (Account 5880) on line 360.

16. Only University of California teaching hospitals are to complete lines 365 and 370. Enter Support for Clinical Teaching (Account 5910) and Teaching Allowances (Account 5890) on lines 365 and 370, respectively.

17. Enter policy discounts (account 5920) administrative adjustments (Account 5930), and other deductions from revenue (Account 5940) on lines 375, 380, and 385, respectively.

18. Sum deductions from revenue amounts, lines 300 through 385, and enter the total on line 395. Enter the same total on line 105. This total must agree with page 12, column 23, line 455.

19. Go to line 430. Enter on line 430 the Medicare capitation premium revenue (Account 5960). The figure on line 430 must equal page 12, column 3, line 457.

20. Enter on line 435 the Medi-Cal capitation premium revenue (Account 5970). The figure on line 435 must equal page 12, column 7, line 457.

21. Enter on line 440 the County Indigent Programs capitation premium revenue (Account 5980). The figure on line 440 must equal page 12, column 11, line 457.

22. Enter on line 445 the Other Third Parties capitation premium revenue (Account 5990). The figure on line 445 must equal page 12, column 15, line 457.

23. Total lines 430 through 445 and enter the result on line 450. Enter the same total on line 107. This total must agree with page 12, column 23,

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line 457.

24. Go to line 110. Subtract deductions from revenue on line 105 from gross patient revenue on line 30, then add capitation premium revenue on line 107 and enter the resulting net patient revenue on line 110. The figure on line 110 must equal page 12, column 23, line 460.

25. Enter on line 135 total other operating revenue from page 14, column 1, line 280.

26. Add net patient revenue and total other operating revenue on lines 110 and 135, and enter the resulting total operating revenue on line 140.

27. Enter on line 146 the sum of Daily Hospital Services total direct expenses from page 17, column 10, line 150, plus the professional component amount from page 15, column 9, line150.

28. Enter on line 151 the sum of Ambulatory Services total direct expenses from page 17, column 10, line 225, plus the professional component amount from page 15, column 9, line 225.

29. Enter on line 156 the sum of Ancillary Services total direct expenses from page 17, column 10, line 405, plus the professional component amount from page 15, column 9, line 405.

30. Enter on line 161 the Research total direct expenses from page 18, column 10, line 10.

31. Enter on line 166 the Education total direct expenses from page 18, column 10, line 50.

32. Enter on line 171 the General Services total direct expenses from page 18, column 10, line 150.

33. Enter on line 176 the Fiscal Services total direct expenses from page 18, column 10, line 200.

34. Enter on line 181 the Administration total direct expenses from page 18, column 10, line 300.

35. Enter on line 186 the Unassigned Costs total direct expenses from page 18, column 10, line 360.

36. Enter on line 190 the Purchased Inpatient Services total direct expenses from page 17, column 10, line 410.

37. Enter on line 195 the Purchased Outpatient Services total direct expenses from page 17, column 10, line 411.

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38. Total lines 146 through 195 and enter the result on line 200. Line 200 must agree with page 18, column 10, line 365 plus page 16, column 9, line 305.

39. Subtract total operating expense line 200 from total operating revenue line 140 and enter net from operations on line 205.

40. Go to line 500. Enter gains on sale of hospital property (Account 9010) on line 500.

41. Enter maintenance of restricted funds revenue (Account 9030) on line 505.

42. Enter unrestricted contributions (Account 9040) on line 510.

43. Enter donated services (Account 9050) on line 515.

44. Enter income, gains and losses from unrestricted investments (Account 9060) on line 520. Include all unrestricted non-patient interest income.

45. Enter unrestricted income from endowment funds (Account 9070) on line 525.

46. Enter unrestricted income from other restricted funds (Account 9080) on line 530.

47. Enter term endowment funds becoming unrestricted (Account 9090) on line 535.

48. Enter transfers from restricted funds for non-operating expenses (Account 9100) on line 540.

49. District hospitals enter assessment revenue (Account 9150), county allocation of tax revenue (Account 9160), special district augmentation revenue (Account 9170), debt service tax revenue (Account 9180), and State Homeowner's Property Tax Relief (Account 9190) on lines 545, 550, 555, 560, and 565, respectively.

50. State and district hospitals only enter on line 570 the amount appropriated from the State General Fund (Account 9200) or other State sources for operating deficits or other operating needs. The amount reported should not exceed the actual amount of the appropriation(s) expended and/or encumbered.

51. County hospitals enter on lines 575, 580, and 585, the amount appropriated from the County General Fund or other sources for operating deficits or other operating needs. Enter on line 575 the amount of Realignment funds unrelated to direct patient care (Account 9210) provided to the hospital. See Section 1280 of the Manual for more information on Realignment Funds. Enter on line 580 the amounts of County General Funds provided (Account 9220). Enter on line 585 the amount of Other Funds (Account 9230) provided by the County. The amounts reported should not exceed the actual amount of the

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appropriations(s) expended and/or encumbered. If a County hospital repays the County any portion of the County appropriations(s), the repayment must be abated against current year appropriations.

52. Enter physicians' offices and other rentals revenue (Account 9250) on line 590.

53. Enter on line 595 medical office building revenue (Account 9260).

54. Enter on line 600 child care service revenue (non-employees) (Account 9270).

55. Enter on line 605 family housing revenue (Account 9280).

56. Enter retail operations revenue (Account 9290) on line 610.

57. Enter other non-operating revenue (Account 9400) on line 615.

58. Total lines 500 through 615 and enter the resulting total non-operating revenue on line 625.

59. Enter losses on sale of hospital property (Account 9020) on line 640.

60. Enter maintenance of restricted funds expenses (Account 9030) on line 645.

61. Enter physicians' offices and other rentals expenses (Account 9510) on line 650.

62. Enter on line 655 medical office building expense (Account 9520).

63. Enter on line 660 child care service expense (Non-Employees) (Account 9530).

64. Enter on line 665 family housing expense (Account 9540).

65. Enter retail operations expenses (Account 9550) on line 670.

66. Enter other non-operating expenses (Account 9800) on line 675.

67. Total lines 640 through 675 and enter the resulting total non-operating expenses on line 685. This amount must agree with page 18, column 10, line 370.

68. Subtract line 685 from line 625 and enter net non-operating revenue and expenses on line 700. Transfer this total to line 210.

69. District hospitals enter on line 705 the amount of interest expense on long-term debt included on page 8, line 186.

70. Go to line 215. Total lines 205 and 210 and enter the resulting net income before taxes and extraordinary items on line 215.

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71. Enter current provision for income taxes (Accounts 9901 and 9903) on line 220.

72. Enter deferred provision for income taxes (Accounts 9902 and 9904) on line 225.

73. Subtract lines 220 and 225 from line 215 and enter the resulting net income before extraordinary items on line 230.

74. Enter extraordinary items (Account 9920 on lines 235 and 240 Provide a brief description (up to 50 characters) of each item. Enter extraordinary income amounts as negative (bracketed) figures.

75. Subtract lines 235 and 240 from line 230 and enter the resulting net income (loss) on line 245.

Page 1 HOSPITAL DESCRIPTION 7020.13

This page reports some descriptive information about the hospital, such as: Type of Control, Type of Care, and a profile of the active medical staff.

1. Enter on line 5, column 1, the number of licensed beds at the end of the reporting period. The number of licensed beds must agree with page 4.1, column 1, line 150. Total licensed beds must include residential care beds where medical care is given; even though these beds are not licensed by the same agency licensing acute care beds. Do not include licensed beds placed in suspense.

2. Enter on line 10 the daily average complement of beds (excluding bassinets) physically existing and actually available for overnight use, regardless of staffing levels. Do not include beds in nursing units converted to uses other than inpatient overnight accommodations which cannot be placed back into service within 24 hours. The number of available beds may be and often is less than the number licensed. On rare occasions, such as pending license application for a new inpatient service, the number of available beds may exceed the licensed beds. The number of available beds must agree with page 4.1, column 2, line 150.

3. Enter on line 15, column 1, the daily average complement of beds fully staffed during the reporting period. Staffed beds are those beds set up, staffed, equipped and in all respects ready for use by patients remaining in the hospital overnight. Hospitals typically staff for those beds currently occupied by inpatients, plus an increment for unanticipated admissions. The number of staffed beds must equal page 4.1, column 3, line 150.

4. Enter on line 20, column 1, the number of the Health Service Area (HSA) (from the following list) in which the hospital is located.

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County No.	County Name	HSA No.	County No.	County Name	HSA No.
01	Alameda	5	30	Orange	13
02	Alpine	6	31	Placer	2
03	Amador	6	32	Plumas	1
04	Butte	1	33	Riverside	12
05	Calaveras	6	34	Sacramento	2
06	Colusa	1	35	San Benito	8
07	Contra Costa	5	36	San Bernardino	12
08	Del Norte	1	37	San Diego	14
09	El Dorado	2	38	San Francisco	4
10	Fresno	9	39	San Joaquin	6
11	Glenn	1	40	San Luis Obispo	8
12	Humboldt	1	41	San Mateo	4
13	Imperial	14	42	Santa Barbara	10
14	Inyo	12	43	Santa Clara	7
15	Kern	9	44	Santa Cruz	8
16	Kings	9	45	Shasta	1
17	Lake	1	46	Sierra	2
18	Lassen	1	47	Siskiyou	1
19	Los Angeles	11	48	Solano	3
20	Madera	9	49	Sonoma	3
21	Marin	4	50	Stanislaus	6
22	Mariposa	9	51	Sutter	2
23	Mendocino	1	52	Tehama	1
24	Merced	6	53	Trinity	1
25	Modoc	1	54	Tulare	9
26	Mono	12	55	Tuolumne	6
27	Monterey	8	56	Ventura	10
28	Napa	3	57	Yolo	2
29	Nevada	2	58	Yuba	2

5. If the hospital has been designated as a trauma center, enter on line 30 column 1, the level (1, 2, or 3) designated by the local Emergency Medical Services Agency. The requirements for each trauma center level are set forth in Title 22, Division 9, Chapter 7, of the California Code of Regulations.

6. Place an "X" on the most appropriate line in column 2, lines 5 through 55, to indicate the hospital's type of control. Only one item is to be indicated. Pick the response which is most descriptive.

7. Place an "X" on the line in column 3, lines 5 through 40, which reflects the preponderance of care provided by your facility. Only one item is to be indicated. Short-term is defined as an average length of stay of less than 30 days. Long-term is defined as an average length of stay of 30 days or longer.

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8. Place an "X" in column 1, lines 60 through 105, for each government program in which the hospital is participating. Specify other programs, as appropriate, on lines 90 through 105 (up to 30 characters per line).

9. If the hospital participated in HMO type capitation programs or contracted with governmental and other programs on a capitation basis, enter in column 2, lines 60 through 85, the number of contracts for each type of program in which the hospital participated during the reporting period. Enter in the space to the left of column 2, on lines 90 through 105, a short description (up to 30 characters per line) of program types not listed in which the hospital participated and enter the number of contracts for each type in column 2.

10. Place an "X" in column 3, lines 60 through 95, to identify 24-hour on-premises coverage of services specified. Do not check if the service on any shift of any day is covered with "on-call" staff.

11. For lines 110 through 315, enter the number of active medical staff by clinical specialty as of the report period end for hospital-based physicians in columns 1 through 3 and non-hospital-based physicians in columns 4 through 6, as appropriate. Active medical staff is defined as those hospital-based and non-hospital based physicians who are voting members of and can hold office in the Medical Staff organization of the hospital. Appointments: 1) Attending, 2) Associate, 3) House Staff, 4) Courtesy, and 5) Consulting. Of these five medical staff classifications, only the first three (Attending, Associate, and House Staff) meet our definition of active medical staff. If a physician has more than one specialty, count only one. Use the specialty in which the physician practices the most while at the reporting hospital. Following are definitions of certain terms related to the completion of this information:

    Hospital-based physician - This term refers to a physician who performs services in a hospital setting for hospital patients; and either (1) has a financial arrangement (salary or contract) under which he is compensated by or through a hospital for in-patient and/or outpatient services, or (2) bills patients separately for his services. Such physicians may also receive compensation from medical schools or other organizations which have arrangements with the hospital for the services they render to hospital patients. Hospital-based physicians typically include pathologists and radiologists as well as physicians who staff emergency rooms and other ambulatory and ancillary cost centers.

    Non-hospital-based physician - This term refers to a physician other than hospital-based that is on the hospital's active medical staff and has staff privileges.

REPORTING REQUIREMENTS

Board certified - This term refers to a physician who has met all educational and residency requirements and has passed the required national examination.

Board eligible - This term refers to a physician who has met all educational and residency requirements and is eligible to take the national examination, but has not passed it.

Other - This term refers to a physician who has not met the necessary requirements to sit for the national examination.

12. Enter the number of full-time equivalent (FTE) residents and fellows in to two decimal places in columns 7 and 8. (Enter zeros if necessary.) Interns are considered first year residents and are to be included in the residents columns. Fellows are graduates of a school of medicine or osteopathy who have had a period of postdoctoral medical education and are pursuing a more individualized course of training in a specific field of interest. Fellows include advanced residents who have already completed the minimum number of years of training required for board eligibility. FTE is defined as the number of paid residency/fellowship months divided by 12. Partial months are counted as one when one half or more of the month is worked and not counted when less than half of the month is worked. For example, three residents paid a total of 18 months during the reporting period, would be 1.50 FTEs. The FTEs reported on this page must also be reported on page 18, column 13, and on page 19, column 21.

13. Total lines 110 through 315, columns 1 through 8, and enter the totals on line 320.

Page 2 SERVICES INVENTORY 7020.14

This page is used to report the various services offered and not offered by the hospital at any time during the report period and how the services are provided as explained by the following code definitions. Each item must be coded. If a particular service is not available, it is to be coded with a "6". Enter the appropriate code in columns 1, 2, and 3 for each of the services specified. The codes are defined as follows:

1. Separately organized, staffed, and equipped unit of hospital.

   This would be a separate (discrete) unit of the hospital. Examples would include separate medical intensive care unit, coronary care unit, respiratory therapy unit, etc.

2. Services maintained in hospital.

   When a service is provided by hospital personnel as a function of a separately organized unit, this code would be used. Also, when two

REPORTING REQUIREMENTS

or more functional units are combined into one responsibility unit, this code would be used. Examples might include (1) open heart surgery or plastic surgery when these services are performed in the regular operating suite and (2) intensive care and coronary care when these services are organized into a single nursing unit.

3. Service contracted but hospital based.

   This code would be used for a contracted service which is hospital based. The contractor staffs the service rather than the hospital. Such service is billed by the hospital.

4. Services not maintained in hospital but available from outside contractor or other hospital.

   This code would be used for services not maintained in the hospital but available from an outside contractor. Examples would include services purchased from independent laboratories and another hospital. Such services are billed by the hospital.

5. Service not provided in hospital but shared with another hospital under contract.

   This code would be used for services not maintained in the hospital but available under contract as a shared service with another hospital. Do not use this code if patients are only referred to another facility for service.

6. Services not available.

   When a service is not available and no formal referral agreement or contract exists, this code would be used.

7. Special code for clinical services.

   This code is used when the clinic services are commonly provided in the emergency suite to non-emergency outpatients by hospital-based physicians or residents. Use this code only for clinic services in columns 2 and 3. The revenue and expenses associated with such services must be reported in the Clinic revenue/cost center.

8. Service available at but not billed by hospital.

   This code is used for services which are obtainable at the hospital, but are not billed by the hospital.

9. Service available, but not used during reporting cycle.

   This code is used for services which are obtainable at or through the hospital, but were not used during the reporting period.

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Revenue, expenses, and units of service must be reported for every service listed on this report page that is coded 1, 2, 3, 4, 5, or 7. The above cross reference list has been prepared for use in verifying that the revenue and cost centers reported are consistent with the services inventory. The cross reference list is the same form as report page 2 except that the code columns have been completed with pages 12 and 17 or 18 line numbers that correspond to that service. Thus, for every service that is coded 1, 2, 3, 4, 5 or 7, the cross reference list indicates which revenue centers on page 12 must have revenue and which cost centers on pages 17 or 18 must have expenses. Where the cross reference list indicates more than one line, at least one of the lines listed must have revenue on page 12 and expenses on pages 17, or expenses on 18. Any inconsistencies between the services inventory and the revenue reported on page 12 and the expenses reported on pages 17, or the expenses reported on 18 must be footnoted on page 2.

NOTE: Alternative Birthing Center (ABC) on line 60, column 1, and Combined Labor/Delivery Birthing Room (L/DR) line 250, column 1, are different in that the ABC uses licensed beds and the combined L/DR uses unlicensed labor room beds.

Sub-Acute Care on lines 175 and 177, column 1, is a very intensive, licensed skilled nursing program.

Milieu Therapy on line 225, column 2, is defined as a type of psychotherapy in which the total environment is utilized in treating mental and behavioral disorders through patient-group interaction, staff support and understanding, and a total, humanistic approach.

SERVICES INVENTORY

Cross references to pages 12, 17 and 18 line numbers

Line No.		(1) Code		(2) Code		(3) Code
	DAILY HOSPITAL SERVICES		LABORATORY SERVICES (con'd)		CLINIC SERVICES (con'd)	
5	INTENSIVE CARE SERVICES		Microbiology	260	Dental	175
10	Burn	15, 30	Necropsy	265	Dermatology	175
15	Coronary	10, 15	Serology	260	Diabetes	175
20	Medical	5, 15	Surgical Pathology	265	Drug Abuse	175
25	Neonatal	20	DIAGNOSTIC IMAGING SERVICES		Family Therapy	175
30	Neurosurgical	35	Computed Tomography	325	Group Therapy	175
35	Pediatric	15	Cystoscopy	300	Hypertension	175
40	Pulmonary	35	Magnetic Resonance Imaging	315	Metabolic	175
45	Surgical	5, 15	Positron Emission Tomography	400	Neurology	175
50	Definitive Observation Care	40	Ultrasonography	320	Neonatal	175
55	ACUTE CARE SERVICES		X-Ray - Radiology	300	Obesity	175
60	Alternate Birthing Center (licensed beds)	70	DIAGNOSTIC THERAPEUTIC SERVICES		Obstetrics	175
65	Geriatric	45	Audiology	375	Ophthalmology	175
70	Medical	45, 50	Biofeedback Therapy	400	Orthopedic	175
75	Neonatal	50	Cardiac Catheterization	280	Otolaryngology	175
80	Oncology	45, 50	Cobalt Therapy	305	Pediatric	175
85	Orthopedic	45, 50	Diagnostic Radioisotope	305	Pediatric Surgery	175
90	Pediatric	50	Echocardiology	275	Podiatry	175
95	Physical Rehabilitation	50, 80	Electrocardiology	285	Psychiatric	175
100	Post Partum	65	Electroencephalography	295	Renal	175
105	Surgical	45, 50	Electromyography	290	Rheumatic	175
107	Transitional Inpatient Care (Acute Beds)	45				
110	NEWBORN CARE SERVICES		Endoscopy	355	Rural Health	175
115	Developmentally Disabled Nursery Care	95	Gastro-Intestinal Laboratory	355	Sugery	175
120	Newborn Nursery Care	95	Hyperbaric Chamber Services	400		
125	Premature Nursery Care	95	Lithotripsy	350	HOME CARE SERVICES	
130	Hospice Care	85	Nuclear Medicine	310	Home Health Aide Services	205
135	Inpatient Care Under Custody (Jail)	205	Occupational Therapy	370	Home Nursing Care (Visiting Nurse)	205
140	LONG-TERM CARE		Physical Therapy	360	Home Physical Medicine Care	205
145	Behavioral Disorder Care	125	Peripheral Vascular Laboratory	400	Home Social Service Care	205
150	Developmentally Disabled Care	125	Pulmonary Function Services	340	Home Dialysis Training	205
155	Intermediate Care	115	Radiation Therapy	305	Home Hospice Care	210
160	Residential/Custodial Care	120	Radium Therapy	305	Home I.V. Therapy Services	205
165	Self Care	120	Radioactive Implants	310	Jail Care	205
170	Skilled Nursing Care	105	Recreational Therapy	375	Psychiatric Foster Home Care	205
175	Sub-Acute Care	100	Respiratory Therapy Services	335		
177	Sub-Acute Care Pediatric	101				
179	Transitional Inpatient Care (SNF Beds)	105				
180	CHEMICAL DEPENDENCY-DETOX		Speech-Language Pathology	365	AMBULATORY SERVICES	
185	Alcohol	75	Sportscare Medicine	360	Adult Day Health Care Center	215
190	Drug	75	Stress Testing	285	Ambulatory Surgery Services	240
195	CHEMICAL DEPENDENCY-REHAB		Therapeutic Radioisotope	310	Comprehensive Outpatient Rehab Facility	220

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SERVICES INVENTORY

Cross references to pages 12, 17 and 18 line numbers

Line No.		(1) Code		(2) Code		(3) Code
200	Alcohol	75	X-Ray Radiology Therapy	305	Observation (Short Stay) Care	195
205	Drug	75	PSYCHIATRIC SERVICES		Satellite Ambulatory Surgery Services	185
210	PSYCHIATRIC SERVICES		Clinic Psychologist Services	175	Satellite Clinic Services	180
215	Psychiatric Acute - Adult	55	Child Care Services	175		
220	Psychiatric - Adolescent and Child	60	Electroconvulsive Therapy (Shock)	380	OTHER SERVICES	
225	Psychiatric Intensive (Isolation) Care	25	Milieu Therapy	390	Diabetic Training Class	400
230	Psychiatric Long-term Care	110	Night Care	200	Dietetic Counseling	175
235			Psychiatric Therapy	390	Drug Reacton Information	400
240	OBSTETRIC SERVICES		Psychopharmacological Thearpy	390	Family Planning	175
245	Abortion Services	235	Sheltered Workshop	390	Genetic Counseling	175
250	Combined Labor/Delivery Birthing Room	230	RENAL DIALYSIS		Medical Research P.18	5
255	Delivery Room Services	230	Hemodialysis	345	Parent Training Class	175
260	Infertility Services	400	Home Dialysis Support Services	345	Patient Representative	80
265	Labor Room Services	230	Peritoneal	345	Public Health Class P.18	280
270	SURGERY SERVICES		Self-Dialysis Training	345	Social Work Services P.18	80
275	Dental	235	Organ Acquisition	395	Toxicology/Antidote Information P.18	295
280	General	235	Blood Bank	270	Vocational Services P.18	80
285	Gynecologic	235	Extracorporeal Membrane Oxygenation	335		
290	Heart	235	Pharmacy	330	MEDICAL EDUCATION PROGRAMS	
295	Kidney	235			Approved Residency P.18	30
300	Neurosurgical	235	EMERGENCY SERVICES		Approved Fellowship P.18	30
305	Open Heart	235	Emergency Communications System	160	Non-Approved Residency P.18	30
310	Ophthamologic	235	Emergency Helicopter Service	165	Associate Records Technician P.18	250
315	Organ Transplant	235	Emergency Observation Service	160	Diagnostic Radiologic Technologist P.18	35
320	Orthopedic	235	Emergency Room Service	160	Dietetic Intern Program P.18	70
325	Otolaryngolic	235	Heliport	165	Emergency Medical Technician P.18	45
330	Pediatric	235	Medical Transportation	165	Hospital Administration Program P.18	205
335	Plastic	235	Mobile Cardiac Care Service	165	Licensed Vocational Nurse P.18	25
340	Podiatry	235	Orthopedic Emergency Services	160	Medical Technologist Program P.18	35
345	Thoracic	235	Psychiatric Emergency Service	170	Medical Records Administrator P.18	250
350	Urologic	235	Radioisotope Decontamination Room	160	Nurse Anesthetist P.18	35
355	Anesthesia Services	245	Trauma Treatment E.R.	160	Nurse Practitioner P.18	20
360					Nurse Midwife P.18	20
365	LABORATORY SERVICES		CLINIC SERVICES		Occupational Therapist P.18	35
370	Anatomical Pathology	265	AIDS	175	Pharmacy Intern P.18	35
375	Chemistry	260	Alcoholism	175	Physician's Assistant P.18	45
380	Clinical Pathology	265	Allergy	175	Physical Therapist P.18	35
385	Cytogenetics	260	Cardiology	175	Registered Nurse P.18	20
390	Cytology	265	Chest Medical	175	Respiratory Therapist P.18	35
395	Hematology	260	Child Diagnosis	175	Social Worker Program P.18	80
400	Histocompatibility	260	Child Treatment	175		
405	Immunology	260	Communicable Disease	175		

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Page 3.1 - 3.4 RELATED HOSPITAL INFORMATION 7020.15

This page reports certain information concerning the hospital, including: transactions with related organizations; statement of owner compensation; names, occupation, and compensation of owners and governing board members; utilization information on contractual health care purchasers; business relationships of physician owners; and management firm information.

1. Answer item A "yes" if the hospital has incurred any costs resulting from transactions with related organizations as defined by Medicare in 42 CFR 413.17 as follows:

   Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

   The definition of a related organization means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies. Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

2. Answer item B "Yes", if the hospital has costs resulting from transactions with organizations with related personnel. Otherwise, answer "No".

3. If either item A or B was answered "Yes", complete item C. The codes to be entered in column 1 are defined below line 16 and specify which columns are to be completed.

   Proprietary hospitals must complete the information in item D, Statement of Compensation of Owners and their Relatives. Compensation is defined by Medicare regulation 42 CFR 413.102 as follows:

   Compensation means the total benefit received by the owner for services rendered to the institution. It includes: (I) Salary amounts paid for managerial, administrative, professional, and other services, and (ii) Amounts paid by the institution for the personal benefit of the proprietor.

REPORTING REQUIREMENTS

4. Complete E. Trusteed funds are those funds held by a third party that are not reflected on the balance sheet. Examples of trusteed funds include pension plan assets and donated assets held in trust. Board designated assets are not trusteed funds.

5. Item F lists several common hospital cost centers and six general types of financial arrangements which exist between hospital and physicians. Indicate the financial arrangement for each listed service provided at the facility. (See Section 1191 for definitions of financial arrangements.) Comments on lines 33 through 36 are limited to 60 characters each.

6. All hospitals must complete item G for all governing board members. Proprietary hospitals must also complete item G for all owners having a five percent or more interest in the hospital. Enter each person's principal occupation in column 2. Do not report "board member" titles as occupations unless it is their principle occupation. Check column 3 to indicate ownership and column 5 to indicate board membership. Indicate in column 4 the percent of ownership for all owners having a five percent or more interest. Column 6 is to be completed for all owners and board members which received compensation for services rendered personally to or on behalf of the hospitals, regardless of the source. If the owner is not compensated please enter "none".

7. For report periods ending on or after June 30, 2000, skip item H and go to item I. For report periods ending on or before June 29, 2000, complete item H with the patient (census) days and outpatient visits in aggregate for Health Maintenance Organizations as defined by statute to be:

   Any person who undertakes to arrange for the provision of health care services to subscribers enrollees, or to pay for or reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees. This should include those health service plans which are full service plans, or not-for-profit hospital plans.

   All other patient (census) days and outpatient visits for patients treated under contracted plans not included in the above definition will be reported as Other Managed Care. Include Medicare and Medi-Cal managed care in the appropriate category.

8. Item I must be completed only by hospitals which are closely held corporations (10 or fewer owners). Enter in column 1 the name of each physician which is an owner of the hospital, or an owner of the corporation which owns the hospital and has a business relationship with the hospital. For each physician named in column 1, enter in column 2 the percent of the stock owned and describe in column 3 all contract, lease and other business relationships between the hospital and the physician. More than one line may be used for each physician, if needed. (Limit the information entered on each line in column 3 to 60

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characters.)

9. Answer Line 80 (Item J) "yes" if the hospital is operated by a management firm that is not the parent company. If the facility is operated by a management firm complete lines 81 to 102. For item L (lines 88 to 97), limit the services listed on each line to 55 characters. For lines 99 to 102, limit the explanation to 60 characters per line.

Page 4.1 PATIENT CENSUS STATISTICS 7020.16a

This page is required for report periods ending on or before June 29, 2000 and is used to report various patient related statistical information of the hospital, including: licensed beds, available beds, staffed beds, adult and pediatric patient (census) days, Medicare, Medi-Cal, County Indigent Programs, Third-Parties, and Other Payors patient (census) days, number of service discharges, number of hospital discharges, and number of Medicare, Medi-Cal, County Indigent Programs, Third-Parties, and Other Payors discharges. For reports ending on or after June 30, 2000, see Manual section 7020.16b. Third-Parties include all payors liable for a patient's bill other than Title XVIII, Title XIX, County Indigent Programs, Charity, Self-Pay or Other Payors. See Manual sections 7020.2 and 2430.

1. Insert on line 155, column 1 the number of bassinets at the end of the reporting period. On the remaining lines in column 1, enter the number of licensed beds, at the end of the reporting period by discrete Daily Hospital Services cost center as dictated by organizational unit or by beds dedicated for a particular clinical use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. Do not include licensed beds placed in suspense. The total licensed beds in column 1, on line 150, must agree with page 1, column 1, line 5.

2. Insert on line 155, column 2 the reporting period monthly average number of bassinets. Enter on the remaining lines of column 2 the monthly average number of available beds by discrete Daily Hospital Services cost center as dictated by organizational unit or by beds dedicated for a particular clinical use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. The total available beds in column 2, on line 150, must agree with page 1, column 1, line 10.

3. Insert the reporting period monthly average number of staffed bassinets (set up and staffed for use) on line 155, column 3. Enter the monthly average of staffed (set up and staffed) beds by discrete Daily Hospital Services cost center on lines 5 through 145 as dictated by organizational unit or by beds dedicated for a particular clinic use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. The total staffed beds in column 3, line 150, must agree with page 1, column 1, line 15.

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4. Insert adult patient (census) days in column 4 and pediatric patient (census) days in column 5 by the functional Daily Hospital Services cost center related to the level and type of care the patient is receiving as of the point in time of the hospital daily census tabulation. Enter newborn days on line 155, column 5. Recognizing that newborns are neither formally admitted nor discharged, count the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient or newborn (census) day. If a patient is moved from one functional cost center to another, actual patient (census) days spent in each would be reported. If pediatric patients are cared for in a combined adult/pediatric medical/surgical acute unit, the pediatric patient (census) days must be reported in the pediatric acute cost center. GYN patient (census) days are not to be included in the Obstetrics Acute cost center even though the patient may have been housed in that unit. Such patient (census) days must be included in the Medical/ Surgical Acute cost center. Do not enter patient (census) days in the shaded areas.

NOTE: Patient (census) days are the actual days of care rendered during the reporting period. Contrary to Medicare Prospective Payment System requirements, patient (census) days are to include days related to those Medicare patients remaining in the hospital at the end of the reporting period, and are not to include patient (census) days of the prior reporting period for those Medicare patients admitted in the prior period but discharged during the current reporting period.

5. Enter the number of patient (census) days in column 6, by functional Daily Hospital Services cost center, for which Medicare was the principal third-party payor during the patient's period of hospitalization. Enter newborn days on line 155. Patient (census) days are defined as in step 4 above.

6. Enter the number of patient (census) days in column 7, by functional Daily Hospital Services cost center, for which Medi-Cal was the principal third-party payor during the patient's period of hospitalization. Enter newborn days on line 155. Patient (census) days are defined as in Step 4 above.

7. Enter in column 8 the number of County Indigent Programs patient (census) days, by functional Daily Hospital Services cost center, for those patients considered to be covered under County Indigent Programs during all or part of the patient's period of hospitalization. Enter newborn days on line 155. Patient (census) days are defined in Step 4 above.

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A patient under County Indigent Programs is a person for whom counties are responsible under Welfare and Institution (W&I) Code Section 17000, including those programs funded in whole or part by County Medical Services Program (CMSP), California Health Care for Indigents Program (CHIP) or Realignment Funds (or future State subsidy programs) regardless if the hospital renders to the County a bill or other claim for payment.

8. Enter in column 9 the number of Third-Parties patient (census) days for which a payor other than Title XVIII (Medicare) or Title XIX (Medi-Cal) County Indigent Programs or Other Payors was the principal payor during the patient's hospitalization. Enter newborn days on line 155. Patient (census) days are defined in step 4 above.

   A Third-Parties patient is a patient covered by a private indemnity insurance carrier, a Health Maintenance Organization, a Preferred Provider Organization, Crippled Children's' Services, Tricare (CHAMPUS), or California Health and Disability Prevention.

9. Enter in column 10 the number of Other Payors patient (census) days for which a payor other than Title XVIII (Medicare) or Title XIX (Medi-Cal) or County Indigent Program or Third-Parties was the principal payor during the hospitalization. Enter newborn days on line 155. Patient (census) days are defined in step 4 above.

NOTE: Line by line, the sum of patient (census) days in columns 6 through 10 must be equal to the sum of columns 4 and 5.

10. Enter in column 11 the number of service discharges by functional Daily Hospital Services cost center for those patients discharged (transferred) from one cost center to another cost center within the hospital. Service discharges are to be counted by the cost center transferring the patient and not by the cost center receiving the patient. Hospital discharges as defined in Section 4120 of the Manual are not included here.

    When newborn patients must have care beyond that which can be provided in the Nursery, they are transferred to a pediatric unit or a neonatal intensive care unit. Such transfers are not to be counted as service discharges. Such patients are to be formally discharged from the Nursery cost center and formally admitted as regular hospital patients. Therefore, no service discharges should ever be reported for the nursery cost center.

11. Enter in column 12 the total number of discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged. See Section 4120 of the Manual for the definition of a discharge. Report newborn discharges on line 155.

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12. Enter in column 13 the total number of Medicare discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged . Report newborn discharges on line 155.

13. Enter in column 14 the total number of Medi-Cal discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged . Report newborn discharges on line 155.

14. Enter in column 15 the total number of County Indigent Programs patient discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged. Report newborn discharges on line 155.

    A patient under County Indigent Programs is a person for whom counties are responsible under Welfare and Institution (W&I) Code Section 17000, including those programs funded in whole or part by County Medical Services Program (CMSP), California Health Care for Indigents Program (CHIP) or Realignment Funds, (or future State subsidy programs) regardless if the hospital renders to the County a bill or other claim for payment.

15. Enter in column 16 the total number of Third-Parties discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged. Report newborn discharges on line 155.

16. Enter in column 17 the total number of Other Payors patient discharges (including deaths) in the functional Daily Hospital Service cost center from which the patients were discharged. Report newborn discharges on line 155.

    Note: The sum of patient discharges for each cost center in columns 13 through 17 must equal the total discharges in Column 12.

17. Total lines 5 through 145, for all the columns, and enter the results on line 150.

18. Enter on line 156, column 1, the average length of stay (ALOS) for Medi-Cal patients (excluding newborn). Compute Medi-Cal ALOS by dividing Medi-Cal patient (census) days from column 7, line 150 by Medi-Cal discharges from column 14, line 150. Round to two decimal places (enter zeros if necessary).

19. Enter on line 157, column 1 the average length of stay (ALOS) for County Indigent Programs patients (excluding newborn). Compute ALOS by dividing indigent patient (census) days from column 8, line 150, by County Indigent Programs discharges from column 15, line 150. Round to two decimal places (enter zeros if necessary).

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20. Enter on line 158, column 1, the average length of stay (ALOS) for all patients (excluding newborn). This average length of stay is calculated by dividing all patient (census) days from columns 4 and 5, line 150 by total discharges from column 12, line 150. Compute to two decimal places (enter zeros if necessary).

Page 4 PATIENT UTILIZATION STATISTICS 7020.16b

This page is required for report periods ending on or after June 30, 2000 and is used to report various patient related statistical information of the hospital, including: licensed beds, available beds, staffed beds, adult and pediatric patient (census) days, number of hospital discharges, ambulatory and ancillary standard units of measure, and other utilization statistics, such as number of Satellite Ambulatory surgeries and number of referred visits. For report periods ending on or before June 29, 2000, see Manual section 7020.16a.

Lines 5 through 155

1. Insert on line 155, column 1 the number of bassinets at the end of the reporting period. On the remaining lines in column 1, enter the number of licensed beds, at the end of the reporting period by discrete Daily Hospital Services cost center as dictated by organizational unit or by beds dedicated for a particular clinical use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. Do not include licensed beds placed in suspense. The total licensed beds in column 1, on line 150, must agree with page 1, column 1, line 5.

2. Insert on line 155, column 2 the reporting period monthly average number of bassinets. Enter on the remaining lines of column 2 the monthly average number of available beds by discrete Daily Hospital Services cost center as dictated by organizational unit or by beds dedicated for a particular clinical use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. The total available beds in column 2, on line 150, must agree with page 1, column 1, line 10.

3. Insert the reporting period monthly average number of staffed bassinets (set up and staffed for use) on line 155, column 3. Enter the monthly average of staffed (set up and staffed) beds by discrete Daily Hospital Services cost center on lines 5 through 145 as dictated by organizational unit or by beds dedicated for a particular clinic use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. The total staffed beds in column 3, line 150, must agree with page 1, column 1, line 15.

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4. Insert adult patient (census) days in column 4 and pediatric patient (census) days in column 5 by the functional Daily Hospital Services cost center related to the level and type of care the patient is receiving as of the point in time of the hospital daily census tabulation.

   If a patient is moved from one functional cost center to another, actual patient (census) days spent in each would be reported. If pediatric patients are cared for in a combined adult/pediatric medical/surgical acute unit, the pediatric patient (census) days must be reported in the pediatric acute cost center. GYN patient (census) days are not to be included in the Obstetrics Acute cost center even though the patient may have been housed in that unit. Such patient (census) days must be included in the Medical/ Surgical Acute cost center. Do not enter patient (census) days in the shaded areas.

NOTE: Patient (census) days are the actual days of care rendered during the reporting period. Contrary to Medicare Prospective Payment System requirements, patient (census) days are to include days related to those Medicare patients remaining in the hospital at the end of the reporting period, and are not to include patient (census) days of the prior reporting period for those Medicare patients admitted in the prior period but discharged during the current reporting period.

5. Enter in column 11 the number of service discharges by functional Daily Hospital Services cost center for those patients discharged (transferred) from one cost center to another cost center within the hospital. Service discharges are to be counted by the cost center transferring the patient and not by the cost center receiving the patient. Hospital discharges as defined in Section 4120 of the Manual are not included here.

   When newborn patients must have care beyond that which can be provided in the Nursery, they are transferred to a pediatric unit or a neonatal intensive care unit. Such transfers are not to be counted as service discharges. Such patients are to be formally discharged from the Nursery cost center and formally admitted as regular hospital patients. Therefore, no service discharges should ever be reported for the nursery cost center.

6. Enter in column 12 the total number of discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged. See Section 4120 of the Manual for the definition of a discharge.

7. Total lines 5 through 145, for all the columns, and enter the results on line 150.

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Lines 160 through 215

8. Enter the total ambulatory units of service, as reclassified, in column 1, lines 160-215. (See Manual Section 2420 for standard units of measure definitions, and Section 4130 for complete definitions of visits.) Enter the inpatient ambulatory units of service in column 7 and outpatient ambulatory units of service in column 13. The sum of columns 7 and 13, line for line, must equal column 1.

Lines 230 through 395

9. Enter total ancillary units of service, as reclassified, in column 1, lines 230 through 395. Enter inpatient ancillary units of service in column 7 and outpatient ancillary units of service in column 13. The sum of columns 7 and 13, line for line, must equal column 1.

Lines 505 through 560

10. Enter the number of surgeries performed at Satellite Ambulatory Surgery Centers during the reporting period on line 505, column 1.

11. Enter in column 1, line 510 the number of discrete operating rooms existing at Satellite Ambulatory Surgery Centers.

12. Enter the number of surgeries performed in Surgery and Recovery during the reporting period on line 515, column 1.

13. Record the number of surgery minutes related to open heart surgeries on line 520, column 1. See the account description for the Surgery and Recovery cost center in this Manual for the definition of surgery minutes.

14. Insert the number of open heart surgeries performed during the reporting period on line 525, column 1.

15. Enter on line 530, column 1, the number of inpatient or combined inpatient/outpatient operating rooms as of the last day of the reporting period. Do not include operating rooms used exclusively for outpatients.

16. Enter the number of surgeries performed in Ambulatory Surgery Services during the reporting period on line 535, column 1.

17. Enter in column 1, line 540, the number of discrete ambulatory (outpatient) operating rooms used exclusively for outpatients as of the last day of the reporting period.

18. Enter the number of observation care days for patients in organized observation care programs on line 545, column 1. See Section 4130 for the definition of an observation care day.

REPORTING REQUIREMENTS

19. Enter the number of Renal Dialysis Care visits on line 550, column 1. See Section 4130 for the definition of a renal dialysis visit.

20. Enter the number of referred outpatient ancillary services visits on line 555, column 1. See Section 4130 for the definition of a private referred ancillary services outpatient visit.

21. On line 560, column 13, enter the sum of lines 160, 170, 175, 180, 190, 200, 205, 210, 215, 505, 515, 535, 545, 550, and 555. Enter the same total outpatient visits in column 1.

Page 4.2 AMBULATORY, ANCILLARY AND OTHER UTILIZATION STATISTICS 7020.17a

This report page is required for report periods ending on or before June 29, 2000 and is used to report ambulatory and ancillary standard units of measure and other utilization statistics, such as number of Satellite Ambulatory surgeries and number of referred visits. For reports ending on or after June 30, 2000, see Manual section 7020.16b. Ambulatory standard units of measure (units of service) are required to be reported by inpatient and outpatient and by source of payment (Medicare, Medi-Cal, County Indigent Programs, Third-Party, and Other). Ancillary standard units of measure (units of service) are required to be reported by inpatient and outpatient.

NOTE: Hospitals must develop systems to maintain units of service by payor. Allocation of units based on gross revenue is not acceptable. If the hospital is unable to meet this requirement, modifications must be requested from the Office and may be used only after receiving written approval from the Office.

Lines 160-215

1. Enter the total ambulatory units of service, as reclassified, in column 1, lines 160-215. (See Manual Section 2420 for standard units of measure definitions, and Section 4130 for complete definitions of visits.)

2. Report inpatient units of service by payor in columns 2 through 6, and outpatient units of services by payor in column 8 through 12.

3. Enter in column 2 the inpatient units of service related to those patients for which Medicare was the principal payment source.

4. Enter in column 3 the inpatient units of service related to those patients for which Medi-Cal was the principal payment source.

5. Enter in column 4 the inpatient units of service related to those patients for which County Indigent Programs was the principal payment source.

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6. Enter in column 5 the inpatient units of service for which a Third-Party other than Medicare, Medi-Cal or County Indigent Programs was the principal payment source.

7. Enter in column 6 the inpatient units of service for which the principal payment course was other than Medicare, Medi-Cal, County Indigent Programs or Third-Party.

8. Enter the total inpatient units of service (sum of columns 2 through 6) in column 7.

9. Enter in column 8 the outpatient units of service related to those patients for which Medicare was the principal payment source.

10. Enter in column 9 the outpatient units of service related to those patients for which Medi-Cal was the principal payment source.

11. Enter in column 10 the outpatient units of service related to those patients for which County Indigent Programs was the principal source of payment.

12. Enter in column 11 the outpatient units of service for which a Third-Party other than Medicare, Medi-Cal or County Indigent Programs was the principal payment source.

13. Enter in column 12 the outpatient units of services for which the principal payment source was other than Medicare, Medi-Cal, County Indigent Programs of Third-Party.

14. The sum of columns 8 through 12 must be added to arrive at column 13. Line by line, the sum of columns 7 and 13 must equal column 1.

Lines 230-410

15. Enter total ancillary units of service, as reclassified, in column 1, lines 230 through 410. Enter inpatient ancillary units of service in column 7 and outpatient ancillary units of service in column 13. The sum of columns 7 and 13, line for line, must equal column 1.

Lines 505 through 560

16. Enter the number of surgeries performed at Satellite Ambulatory Surgery Centers during the reporting period on line 505, column 1 and by principal source of payment in columns 2 through 12. You must report the actual number of surgeries by payor. Do not allocate surgeries based on operating minutes or gross patient revenue.

17. Enter in column 1, line 510 the number of discrete operating rooms existing at Satellite Ambulatory Surgery Centers.

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18. Enter the total number of surgeries performed during the reporting period on line 515, column 1. Enter inpatient and outpatient surgeries by principal payment source in columns 2 through 12. You must report the actual number of surgeries by payor. Do not allocate surgeries based on operating minutes or gross patient revenue.

19. Record the number of surgery minutes related to open heart surgeries on line 520, column 1 and by principal source of payment in columns 2 through 6. See the account description for the Surgery and Recovery cost center in this Manual for the definition of surgery minutes.

20. Insert the number of open heart surgeries performed during the reporting period on line 525, column 1 and by principal source of payment in columns 2 through 6.

21. Enter on line 530, column 1, the number of inpatient or combined inpatient/outpatient operating rooms as of the last day of the reporting period. Do not include operating rooms used exclusively for outpatients.

22. Enter the number of surgeries performed in Ambulatory Surgery Services during the reporting period on line 535, column 1 and by patient type and principal source of payment in columns 2 through 12.

23. Enter in column 1, line 540, the number of discrete ambulatory (outpatient) operating rooms used exclusively for outpatients as of the last day of the reporting period.

24. Enter the number of observation care days for patients in organized observation care programs on line 545, column 1, and by principal source of payment in columns 2 through 12. See Section 4130 for the definition of an observation care day.

25. Enter the number of Renal Dialysis Care visits on line 550, column 1, and by principal source of payment in columns 8 through 12. See Section 4130 for the definition of a renal dialysis visit.

26. Enter the number of referred outpatient ancillary services visits on line 555, column 1, and by principal source of payment in columns 8 through 12. See Section 4130 for the definition of a private referred ancillary services outpatient visit.

27. On line 560, columns 8 through 13, enter the sum of lines 160, 170, 175, 180, 190, 200, 205, 210, 215, 505, 515, 535, 545, 550, and 555. Total columns 8 through 12, line 560 and enter the resulting total outpatient visits in column 1.

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Page 4.1 PATIENT UTILIZATION STATISTICS BY PAYER 7020.17b

This page is required for report periods ending on or after June 30, 2000 and is used to report patient related statistics, such as patient (census) days, hospital discharges, and outpatient visits, by payor category for various types of care. For report periods ending on or before June 29, 2000, see Manual section 7020.17a. The payor categories are Medicare - Traditional, Medicare - Managed Care, Medi-Cal -Traditional, Medi-Cal - Managed Care, County Indigent Programs - Traditional, County Indigent Programs - Managed Care, Other Third Parties - Traditional, Other Third Parties - Managed Care, Other Indigent, and Other Payors. For payor category descriptions, see Manual sections 2230, and 2430.

NOTE: Report patient (census) days by type of care as of the point in time of the hospital daily census count. Recognizing that nursery patients are neither formally admitted nor discharged, count the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient or nursery patient (census) day. If a patient is moved from one type of care to another, actual patient (census) days spent in each would be reported.

NOTE: Patient (census) days are the actual days of care rendered during the reporting period. Contrary to Medicare Prospective Payment System requirements, patient (census) days are to include days related to those Medicare patients remaining in the hospital at the end of the reporting period, and are not to include patient (census) days of the prior reporting period for those Medicare patients admitted in the prior period but discharged during the current reporting period.

Lines 5 through 45

1. Enter the number of Medicare - Traditional patient (census) days in column 1, by type of care, for which Medicare was the principal third party payor during the patients period of hospitalization. Do not include patient (census) days related to Medicare - Managed Care. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

2. Enter the number of Medicare - Managed Care patient (census) days in column 2, by type of care, for which a managed care plan funded by Medicare was the principal third party payor during the patients period of hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

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3. Enter the number of Medi-Cal - Traditional patient (census) days in column 3, by type of care, for which Medi-Cal was the principal third party payor during the patients period of hospitalization. Do not include patient (census) days related to Medi-Cal - Managed Care. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

4. Enter the number of Medi-Cal - Managed Care patient (census) days in column 4, by type of care, for which a managed care plan funded by Medi-Cal was the principal third party payor during the patients period of hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

5. Enter in column 5 the number of County Indigent Programs - Traditional patient (census) days , by type of care, for those patients considered to be covered under County Indigent Programs during all or part of the patient's period of hospitalization. Do not include patient (census) days related to County Indigent Programs - Managed Care. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

   A patient under County Indigent Programs - Traditional is a person for whom counties are responsible under Welfare and Institution (W&I) Code Section 17000, including those programs funded in whole or part by County Medical Services Program (CMSP), California Health Care for Indigents Program (CHIP) or Realignment Funds, (or future State subsidy programs) regardless if the hospital renders to the County a bill or other claim for payment.

6. Enter the number of County Indigent Programs - Managed Care patient (census) days in column 6, by type of care, for those patients covered by a managed care plan funded by a county under County Indigent Programs during all or part of the patient's hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

   A patient under County Indigent Programs - Managed Care is a person for whom a county is responsible under Welfare and Institution (W&I) Code Section 17000 and is covered by a managed care plan funded by that county.

7. Enter the number of Other Third Parties - Traditional patient (census) days in column 7, by type of care, for which a third party payor other than Title XVIII (Medicare), Title XIX (Medi-Cal), County Indigent Programs, Other Payors, or managed care plan was the principal payor during the patient's hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

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An Other Third Parties - Traditional patient is a patient covered by a private indemnity insurance carrier, Crippled Children's' Services, Workers' Compensation, Tricare (CHAMPUS), Short-Doyle, or California Health and Disability Prevention. Do not include patients covered by a managed care plan.

8. Enter the number of Other Third Parties - Managed Care patient (census) days in column 8, by type of care, for which a managed care plan (Health Maintenance Organizations, Health Maintenance Organizations with Point-of-Service option (POS), Preferred Provider Organizations, Exclusive Provider Organizations, Exclusive Provider Organizations with Point-of-Service option, etc.) other than one funded by Medicare, Medi-Cal, or a county, was the principal third party payor during the patients period of hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

9. Enter the number of Other Indigent patient (census) days in column 9, by type of care, for indigent patients who are not recorded in the County Indigent Programs category and are being provided charity care by the hospital.

10. Enter in column 10 the number of Other Payors patient (census) days for which a payor other than Title XVIII (Medicare), Title XIX (Medi-Cal), County Indigent Program, Other Third-Party, managed care plan, or Other Indigent was the principal payor during the hospitalization.

11. Enter the total patient (census) days, by type of care, in column 11. Line by line, the sum of patient (census) days in columns 1 through 10 must equal column 11. The total patient (census) days in column 11, on line 35, must agree with page 4, sum of columns 4 and 5, line 150.

NOTE: See Manual Section 4120 for the definition of a discharge. When newborn patients must have care beyond that which can be provided in the Nursery, they are transferred to a pediatric unit or a neonatal intensive care unit. Such patients are to be formally discharged from the Nursery cost center and formally admitted as regular hospital patients.

12. Enter in column 12 the total number of Medicare - Traditional discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

13. Enter in column 13 the total number of Medicare - Managed Care discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

REPORTING REQUIREMENTS

14. Enter in column 14 the total number of Medi-Cal - Traditional discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

15. Enter in column 15 the total number of Medi-Cal - Managed Care discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

16. Enter in column 16 the total number of County Indigent Programs - Traditional discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

17. Enter in column 17 the total number of County Indigent Programs - Managed Care discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

18. Enter in column 18 the total number of Other Third Parties - Traditional discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

19. Enter in column 19 the total number of Other Third Parties - Managed Care discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

20. Enter in column 20 the total number of Other Indigent discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

21. Enter in column 21 the total number of Other Payors discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

22. Enter the total discharges, by type of care, in column 22. Line by line, the sum of discharges in columns 12 through 21 must equal column 22. The total discharges in column 22, on line 35, must agree with page 4, column 12, line 150.

Lines 60 through 110

NOTE: See Manual Section 4130 for complete definitions of visits.

23. Enter on line 60, the number of emergency services outpatient visits, including psychiatric emergency room outpatient visits, by principal source of payment in columns 1 through 10.

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24. Enter on line 65, the number of clinic outpatient visits, including satellite clinic outpatient visits, by principal source of payment in columns 1 through 10.

25. Enter on line 70, the number of outpatient observation care days by principal source of payment in columns 1 through 10.

26. Enter on line 75, the number of psychiatric day-night care days by principal source of payment in columns 1 through 10.

27. Enter on line 80, the number of home health care outpatient visits by principal source of payment in columns 1 through 10.

28. Enter on line 85, the number of hospice outpatient visits by principal source of payment in columns 1 through 10.

29. Enter on line 90, the sum of satellite ambulatory outpatient surgeries, surgery and recovery outpatient surgeries, and ambulatory outpatient surgeries by principal source of payment in columns 1 through 10.

30. Enter on line 95, the number of private referred outpatient visits by principal source of payment in columns 1 through 10.

31. Enter on line 100, the sum of chemical dependency outpatient visits, adult day health care visits, and renal dialysis outpatient visits by principal source of payment in columns 1 through 10.

32. Enter on line 105, the total outpatient visits (sum of lines 60 through 100) by principal source of payment in columns 1 through 10.

33. Complete column 11 with the total outpatient visits for each type of outpatient visit (sum of columns 1 through 10, lines 60 through 110). Column 11, line 105 must equal the sum of column 11, lines 60 through 100. The total outpatient visits in column 11, on line 105, must agree with page 4, column 13, line 560.

Page 5 BALANCE SHEET - UNRESTRICTED FUND 7020.18

This page is the unrestricted fund balance sheet as of the last day of the reporting period. This page is required for every hospital except certain governmental facilities which operate within the General Fund of the related governmental entity. Remember, DO NOT CHANGE LINE LABELS. Include items which do not fit the line labels on the appropriate "other" lines. Lists of additional detail may be submitted on a separate sheet.

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NOTE: All county hospitals operating as a part of the county General Fund must report Property, Plant and Equipment information. Complete lines 80 through 205 of columns 1 and 2 according to Steps 13 through 21 below.

Enter current year data in columns 1 and 3 and prior year data in columns 2 and 4. Effective with reporting periods ending on or after December 31, 1993, prior year data (columns 2 and 4) are optional if the amounts included are the same as reported on the prior year disclosure report (columns 1 and 3). If there has been a restatement or adjustment since the prior report was submitted, the prior year columns must be completed.

All amounts entered in columns 1, 2, 3, and 4, except line 215 in columns 1 and 2, and lines 165 and 200 in columns 3 and 4, must be positive.

Columns 1 and 2.

1. Enter cash (Accounts 1000-1009) on line 5. Remember that negative cash balances must be reported as other current liabilities.

2. Enter marketable securities (Accounts 1010-1019) on line 10.

3. Enter accounts and notes receivable from patients (Accounts 1020-1039) on line 15.

4. Enter estimated uncollectible receivables and third-party contractual withholds (Accounts 1040 through 1049) on line 20 .

5. Enter receivables from third-party payors (Accounts 1050-1059) on line 25.

6. Enter pledges and other receivables (Accounts 1060-1069) on line 30.

7. Enter amounts due from restricted funds (Accounts 1070-1079) on line 35.

8. All inventories (Accounts 1080-1089), computed at the lower of cost or market value, are entered on line 40.

9. Enter intercompany receivables (Accounts 1090-1099) that are short-term on line 45.

10. Enter prepaid expenses and other current assets (Accounts 1100-1109) on line 50.

11. Total lines 5 through 50 (subtracting line 20) and enter total current assets on line 55.

REPORTING REQUIREMENTS

12. If the hospital board has designated (or appropriated) unrestricted assets for special purposes (Account 1110-1139), they are to be entered on lines 60 through 70. Assets so entered must not be included in other line entries. Enter the total of lines 60 through 70 on line 75.

NOTE: Amounts to be entered on lines 80 through 205 must be the historical cost of the assets as appropriate under Generally Accepted Accounting Principles.

13. Enter the historical cost of land (Accounts 1200-1209) on line 80.

14. Enter the historical cost of land improvements (Account 1210-1219) on line 85.

15. Enter the historical cost of buildings and improvements (Accounts 1220-1229) on line 90.

16. Enter the historical cost of leasehold improvements (Accounts 1230-1239) on line 95.

17. Enter the historical cost of equipment (Accounts 1240- 1249) on line 100.

18. Total lines 80 through 100 and enter total Property, Plant and Equipment on line 105.

19. Enter accumulated depreciation and amortization (based on historical cost) for all plant and equipment assets (Accounts 1260-1299) on line 195 as an unbracketed amount.

20. Subtract line 195 from line 105 and enter net total Property, Plant and Equipment result on line 200.

21. Enter the cost of construction in progress (Accounts 1250-1259) on line 205.

22. Enter investments in property, plant and equipment (Accounts 1310-1319) on line 210.

23. Enter accumulated depreciation on investments in plant and equipment (Accounts 1320-1329) on line 215.

24. Enter other investments (Accounts 1330-1339) on line 220.

25. Enter intercompany receivables (Accounts 1340-1349) that are long-term on line 225.

26. Enter other assets (Account 1350-1359) on line 230.

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27. Total lines 210 through 230 and enter total investment and other assets on line 235.

28. Enter goodwill, net of amortization, (Accounts 1360-1369) on line 245.

29. Enter unamortized loan costs (Accounts 1370-1379) on line 250.

30. Enter preopening and other organization costs, net of amortization, (Accounts 1380-1389) on line 255.

31. Other intangible assets (Accounts 1390-1399) are entered on line 260.

32. Total lines 245 through 260 and enter total intangible assets on line 265.

33. Add lines 55, 75, 200, 205, 235 and 265 and enter the resulting total assets on line 270.

34. Enter on line 405 the current market value of the current assets investments reported on line 10.

35. Enter on line 410 the current market value of the board designated marketable securities reported on line 65.

36. Enter on line 415 the current market value of the other investments reported on line 220.

37. Enter on line 420 the estimated total cost to complete the construction in progress reported on line 205.

Columns 3 and 4

38. Enter notes and loans payable (Accounts 2010-2019) on line 5.

39. Enter accounts payable (Accounts 2020-2029) on line 10.

40. Enter accrued compensation and related liabilities (Accounts 2030-2039) on line 15.

41. Enter other accrued expenses (Accounts 2040-2049) on line 20.

42. Advances from third-party payors (Accounts 2050-2059) are entered on line 25.

43. Enter payables to third-party payors (Accounts 2060-2069) on line 30.

44. Enter amounts due to restricted funds (Accounts 2070- 2079) on line 35.

45. Enter income taxes payable (Accounts 2080-2089) on line 40.

46. Enter intercompany payables (Account 2090-2099) that are short-term on line 45.

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47. Current maturities on long-term debt are entered on line 50. This amount is identical to the amount reported on line 125.

48. Enter other current liabilities, including negative cash balances, (Accounts 2100-2109) on line 55.

49. Total lines 5 through 55 and enter total current liabilities on line 60.

50. Enter deferred income taxes (Accounts 2110-2119) on line 65.

51. Enter deferred third-party income (Accounts 2120-2129) on line 70.

52. Enter other deferred credits (Accounts 2130-2139) on line 75.

53. Total lines 65 through 75 and enter total deferred credits on line 80.

54. Enter unpaid principal (including current maturity amounts) for mortgage notes (Accounts 2210-2219) on line 85, construction loans (Accounts 2220-2229) on line 90, notes under revolving credit (Accounts 2230-2239) on line 95, capitalized lease obligations (Accounts 2240-2249) on line 100, bonds payable (Accounts 2250-2259) on line 105, and in intercompany payables (Accounts 2260-2269) on line 110 . The current year detail related to the long-term debt entries on lines 85 through 110 is to be entered on page 5.1 according to instructions following.

55. Enter other non-current liabilities (Accounts 2270-2279) on line 115.

56. Total the long-term debt entries (lines 85 through 115) and enter the result on line 120.

57. Enter current maturities (principal amounts due within one year of the end of the reporting period) of long-term debt (identical to line 50) on line 125 as an unbracketed amount.

58. Subtract the current maturities of long-term debt, line 125, from line 120 and enter the net total long-term debt on line 130.

59. Total lines 60, 80 and 130 and enter total liabilities on line 135.

60. Enter equity amounts on lines 140 through 200 as appropriate. Line 140 is for use by non-profit hospitals to record their unrestricted fund balance. Investor-owned hospitals must complete lines 145 through 165 as appropriate. Partnerships and proprietorships must enter their capital account balance on lines 170 and 175 as

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appropriate. Divisions of a corporation are to enter their divisional equity balances on lines 180 through 200. All hospitals must record their total equity on line 205.

61. Add lines 135 and 205 and enter total liabilities and equity on line 270.

Page 5.1 SUPPLEMENTAL LONG-TERM DEBT INFORMATION 7020.19

This page is required for reporting the long-term debt detail of the various types of long-term debt reported on page 5, column 3, lines 85 through 115. This uniform schedule must be completed by all hospitals that report long-term debt on page 5.

1. Enter in column 5 the line number from page 5, column 3, for which the detail is being provided.

2. Enter in column 6 the year in which the long-term debt obligation was incurred.

3. Enter in column 7 the year in which the final payment of the long-term debt obligation is due.

4. Enter in column 8 the interest rate, rounded to two decimal places, for each long-term debt obligation. If an obligation has more than one interest rate, enter a weighted average interest rate. If the interest rate is "prime" plus a percentage, use the prime rate as of the balance sheet date. If the interest rate is variable, use the rate in effect as of the balance sheet date.

5. Enter in column 9 the unpaid principal as of the balance sheet date. The unpaid principal for each type of debt must total to the amount reported for each type of debt on page 5, column 3.

Page 5.2 STATEMENT OF CHANGES IN PLANT, PROPERTY AND EQUIPMENT 7020.20

This page is the schedule of changes in the plant, property, equipment, and construction-in-progress for the period. This uniform schedule must be completed by all hospitals that report plant, property and equipment on page 5.

1. Enter the beginning balance as the end of the last reporting period in column 1 for applicable capital assets on lines 5 through 30. The amount in column 1, should be identical to amount reported in column 1 for these same line items in the prior year.

2. Enter in column 2, lines 5 through 25, the amount of gross purchases of plant, property and equipment during the reporting period. On line 30, enter the gross amount of additions related to construction-in-progress.

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3. Enter in column 3, the fair market value of plant, property, equipment and construction-in-progress donated to the hospital during the reporting period.

4. Enter in column 4, lines 10 through 20, the value of assets transferred from construction-in-progress for operational use by the hospital. Enter on line 30, the amount of assets transferred out of construction-in-progress. The sum of the column must equal 0.

5. Enter in column 5, the historical cost of plant, property and equipment disposed or retired during the reporting period.

6. For each line in column 6, enter the sum of columns 1 through 5.

7. Enter the sum of lines 5 through 30 on line 35, for columns 1 through 6.

Page 6 BALANCE SHEET - RESTRICTED FUNDS **7020.21**

This page is the restricted funds balance sheet as of the last day of the reporting period. This page is required for all hospitals having restricted assets and/or liabilities. All debts, except amounts due to other funds and certain endowment fund liabilities, are to be accounted and reported as debts of the unrestricted fund.

Enter the asset values of restricted funds at the end of the current year in column 1 and liabilities in column 3. Enter prior year data in columns 2 and 4, as appropriate. Prior year data are not required for the hospital's first reporting year.

Effective with reporting periods ending on or after December 31, 1993, prior year data (columns 2 and 4) are optional if they are the same as reported on the prior year disclosure report (columns 1 and 3). If there is a restatement or adjustment, the prior year columns must be completed.

Columns 1 and 2

Specific Purpose Fund

1. Enter cash (Accounts 1510-1519) on line 5.

2. Enter marketable securities (Account 1521) on line 10.

3. Enter other investments (Account 1529) on line 15.

4. Enter receivables (Accounts 1530-1539) on line 20.

5. Enter amounts due from other funds (Accounts 1540-1549) on line 25.

6. Enter other assets (Accounts 1550-1599) on line 30.

7. Total lines 5, 10, 15, 20, 25, and 30 and enter total assets on line 75.

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Plant Replacement and Expansion Fund

8. Enter cash (Accounts 1410-1419) on line 105.

9. Enter marketable securities (Account 1421) on line 110.

10. Enter mortgage investments (Account 1422) on line 115.

11. Enter real property (Account 1423) net of accumulated depreciation on real property (Account 1424) on line 120.

12. Enter other investments (Account 1429) on line 125.

13. Enter receivables (Accounts 1430-1439) on line 130.

14. Enter amounts due from other funds (Accounts 1440-1449) on line 135.

15. Enter other assets (Accounts 1450-1499) on line 140.

16. Total lines 105, 110, 115, 120, 125, 130, 135 and 140 and enter total assets on line 170.

Endowment Fund

17. Enter cash (Accounts 1610-1619) on line 205.

18. Enter marketable securities (Account 1621) on line 210.

19. Enter mortgage investments (Accounts 1622) on line 215.

20. Enter real property (Account 1623) net of accumulated depreciation on real property (Account 1624) on line 220.

21. Enter other investments (Account 1629) on line 225.

22. Enter receivables (Accounts 1630-1639) on line 230.

23. Enter amounts due from other funds (Accounts 1640-1649) on line 235.

24. Enter other assets (Accounts 1650-1699) on line 240.

25. Total lines 205, 210, 215, 220, 225, 230, 235 and 240 and enter total assets on line 275.

26. Enter on line 405 the current market value of the specific purpose fund marketable securities reported on line 10.

27. Enter on line 410 the current market value of the plant replacement and expansion fund marketable securities reported on line 110.

28. Enter on line 415 the current market value of the endowment fund marketable securities reported on line 210.

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Columns 3 and 4

Specific Purpose Fund

29. Enter amounts due to unrestricted fund (Accounts 2510-2519), plant replacement and expansion fund (Account 2520-2529) and endowment fund (Account 2530-2539) on lines 5, 10 and 15, respectively.

30. Enter fund balance (Accounts 2570-2573) on line 70.

31. Enter the sum of lines 5, 10, 15 and 70 on line 75.

Plant Replacement and Expansion Fund

32. Enter amounts due to unrestricted fund (Accounts 2410-2419) specific purpose fund (Accounts 2420-2429) and endowment fund (Accounts 2430-2439) on lines 105, 110, and 115, respectively.

33. Enter fund balance (Accounts 2470-2473) on line 165.

34. Enter the sum of lines 105, 110, 115 and 165 on line 170.

Endowment Fund

35. Enter mortgages (Accounts 2610-2619) on line 205.

36. Enter other non-current liabilities (Accounts 2620-2629) on line 210.

37. Enter amounts due to unrestricted fund (Accounts 2630-2639) plant replacement and expansion fund (Accounts 2640-2649) and specific purpose fund (Accounts 2650-2659) on lines 215, 220 and 225, respectively.

38. Enter fund balance (Accounts 2670-2673) on line 270.

39. Enter the sum of lines 205, 210, 215, 220, 225 and 270 on line 275.

Page 7 STATEMENT OF CHANGES IN EQUITY 7020.22

This page is used to report the changes in equity between the beginning and ending dates of the reporting period for the unrestricted and restricted funds. This page is required for every hospital except governmental facilities which operate out of the General Fund of the related governmental agency.

1. Enter on line 5 the balance of the equity account at the end of the previous reporting period.

2. Enter prior period audit adjustments on line 10 and any other restatements on lines 15 through 45 and describe in the area provided. (The description on each line is limited to 30 characters.) Remember that prior year contractual revenue adjustments are not to be reported as

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fund balance adjustments unless such differences meet the criteria set forth in Financial Accounting Standards Board Statement No. 16 or are deemed to result from an error as indicated in APB Opinion No. 20. Instead, such amounts are to be included in the statement of revenue and expenses as a current year adjustment to the appropriate contractual adjustment account.

3. Enter the restated balance at the beginning of the current year on line 50. The amount on this line must agree with the ending equity as reported on the balance sheets, pages 5 and 6, in the prior year report; or if the balance sheets have been restated or corrected, as corrected in the prior year column on pages 5 and 6 of the current report.

4. Enter net income (loss) on line 55, column 1 from page 8, column 1, line 245.

5. Enter acquisitions of pooled companies, proceeds from sale of stock and stock options exercised in column 1, lines 60, 65 and 70, respectively.

6. Enter restricted contributions and grants on line 75 in columns 2, 3 or 4, as appropriate.

7. Enter restricted investment income on line 80 in columns 2, 3 or 4, as appropriate.

8 Enter on line 85, columns 2, 3 and 4, amounts transferred to the unrestricted fund as other operating revenue for expenses incurred relating to restricted fund activities.

9. Enter dividends declared on line 90, column 1.

10. Enter donated property on line 95, column 1.

11. Enter intercompany transfers on line 100, column 1.

12. Enter the fund balance transfer amount on line 105, column 1, if the hospital is required to reimburse a government agency for initial contributions made for disproportionate share funds. NOTE: Disproportionate share funds received by hospitals are intended for direct patient care, regardless if related government agencies provided the original funding resources to the State.

13. Enter the other additions to or deductions from equity on lines 110 through 120. Enter deductions as bracketed figures. If additional lines are needed for other items, enter the summary amount on line 110 and attach a separate detail page. DO NOT CHANGE LINE LABELS.

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14. Enter the total of lines 55 through 120 on line 125.

15. In the "Transfers" section of this page, lines 130 through 170, enter only transfers from restricted funds to the unrestricted fund for the acquisition of equipment, the payments on long-term debt, and other such transactions where the amount transferred to the unrestricted fund does not impact the income statement and therefore are not included in the net income (loss) amount on line 55. Enter deductions as bracketed figures. If additional lines are needed for other transfer items, enter the summary amount on line 140 and attach a separate detail page. DO NOT CHANGE LINE LABELS.

16. Enter the total of these transfers, lines 130 through 170, on line 175.

17. Total lines 50, 125 and 175 for each column and enter the equity balances at the end of the year on line 185. The ending equity must agree with the ending equity reported on pages 5 and 6.

NOTE: District Hospitals - Include Bond Interest and Redemption amounts in the Specific Purpose Fund column.

Page 9 STATEMENT OF CASH FLOW - UNRESTRICTED FUND 7020.23

Financial Accounting Standards Board Statement No. 95 requires the Statement of Cash Flows to be completed in place of the Statement of Changes in Financial Position. This statement analyzes the changes in the cash balance which is the difference between line 5 columns 1 and 2 on page 5. The transactions involving cash are divided into three categories (operating, investing, and financing).

NOTE: DO NOT CHANGE LINE LABELS! If additional lines are required, summarize the items on one of the blank lines and attach a separate page with the details.

Enter current year data in column 1 and prior year data in column 2.

Effective with reporting periods ending on or after December 31, 1993, prior year data column 2 is optional if it is the same as reported on the prior year report column 1. If there is a restatement or adjustment, the prior year column must be completed.

When entering changes between current year and prior year assets and liabilities, apply the following rules:

- If assets increase from prior year, enter change as negative (bracketed) amount.
- If assets decreased from prior year, enter change as positive amount.

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- If liabilities increased from prior year, enter change as positive amount.
- If liabilities decreased from prior year, enter change as negative (bracketed) amount.

1. Enter the net income (loss) in column 1, line 5. The net income must match the income reported on page 7, column 1, line 55 and page 8, column 1, line 245.

2. Enter adjustments to reconcile net income to net cash provided by (used for) operating activities and non-operating revenue. If the hospital did not complete column 2, and there are no restatements or other adjustments to the balances, then use the prior year report, column 1, to compute the change.

    a. Enter current year depreciation and amortization expense related to capital assets in column 1, line 15. The amount of depreciation and amortization to be reported must equal the total depreciation and amortization reported on page 8, column 1, line 170.

    b. Enter on line 17, the amortization expense associated with the write-down of intangible assets.

    c. Enter on line 20, the change in marketable securities on page 5, columns 1 and 2, line 10.

    d. Enter on line 30, the change in accounts and notes receivable, net, on page 5, columns 1 and 2, the sum of lines 15 and 20.

    e. Enter on line 35, the change in receivables from third-party payors on page 5, columns 1 and 2, line 25.

    f. Enter on line 40, the change in pledges and other receivables, on page 5, columns 1 and 2, line 30.

    g. Enter on line 45, the change in due from restricted funds on page 5, columns 1 and 2, line 35.

    h. Enter on line 50, the change in inventory on page 5, columns 1 and 2, line 40 .

    i. Enter on line 55, the change in intercompany receivables on page 5, columns 1 and 2, line 45.

    j. Enter on line 57, the change in prepaid expenses and other current assets on page 5, columns 1 and 2, line 50.

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k. Enter on line the 60, the change in accounts payable on page 5, columns 3 and 4, line 10.

l. Enter on line 65, the change on accrued compensation and related liabilities on page 5, columns 3 and 4, line 15.

m. Enter on line 70, the change in other accrued expenses on page 5, columns 3 and 4, line 20.

n. Enter on line 75, the change in advances from other third-party payors on page 5, columns 3 and 4, line 25.

o. Enter on line 80, the change in payables to third-party payors on page 5, columns 3 and 4, line 30.

p. Enter on line 85, the change in due to restricted funds on page 5, columns 3 and 4, line 35.

q. Enter on line 87, the change in income taxes payable on page 5, columns 3 and 4, line 40.

r. Enter on line 90, the change in intercompany payables on page 5, columns 3 and 4, line 45.

s. Enter on line 95, the change in other current liabilities on page 5, columns 3 and 4, line 55.

t. Enter on line 100, the change in deferred credits on page 5, columns 3 and 4, line 80.

u. Enter and describe on lines 102, 103, and 104 other changes in cash flows from operating activities. Enter a gain on sale of hospital property as a negative (bracketed) amount, and a loss on sale of hospital property as a positive amount.

v. Total lines 15 through 100 and enter the total on line 105, column 1 and 2 (if applicable).

w. Enter on line 115 the sum of lines 5 and 105.

3. Cash flows from investing activities include making and collecting loans, and acquiring and disposing of debt or equity instruments and property, plant and equipment and other productive assets. If the hospital did not complete column 2, and there are no restatements or other adjustments to the balances, then use the prior year report, column 1, to compute the change.

a. Enter on line 130 the change in assets whose use is limited on page 5, columns 1 and 2, line 75.

b. Enter on line 135 the total purchases of property, plant,

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equipment and construction-in-progress on page 5.2, column 2, line 35 .

c. Enter and describe on lines 140, 141, and 142 other changes in cash flows from investing activities.

d. Enter on line 145, the sum of lines 130 through 142.

4. Financing activities include obtaining resources from owners and providing them with a return on, and return of, their investment; borrowing money and repaying amounts borrowed, or otherwise settling the obligation; and obtaining and paying for other resources obtained from creditors on long-term credit.

a. Enter on line 160 the amount of proceeds received from the issuance of long-term debt on page 5, columns 3 and 4, line 120.

b. Enter on line 165 the principal repayments on long-term debt on page 5, columns 3 and 4, line 120.

c. Enter on line 170 the amount of proceeds received from the issuance of short-term notes and loans on page 5, columns 3 and 4, line 5.

d. Enter on line 175 the principal repayments on short-term notes and loans on page 5, columns 3 and 4, line 5.

e. Enter on line 180 any dividends paid from page 7, column 1, line 90.

f. Enter on line 185 the proceeds from issuance of common stock from page 7, column 1, line 85.

g. Enter and describe on lines 190, 191, and 192 any other cash flows from financing activities during the reporting period.

5. Enter on line 195 the sum of lines 160 through 192.

6. Enter on line 205 the sum of lines 115, 145 and 195.

7. Enter on line 215 the cash balance, page 5, line 5, at the beginning of the reporting period. This balance may be obtained from the prior year report.

8. Enter on line 230 the sum of lines 205 and 215. This amount must agree with the current year cash balance on page 5, column 1, line 5.

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Page 0 HOSPITAL GENERAL INFORMATION AND CERTIFICATION 7020.24

This page contains general information about the hospital and those involved in completing the disclosure report. In addition, this page contains a certification statement to be signed by the administrator or other responsible official of the hospital.

1. Enter complete legal name of the hospital in item 1.

2. Enter OSHPD Facility Number in item 2. This nine digit number begins with "106" and is assigned by the Office for reporting purposes.

3. Enter in item 3 the name under which the hospital is doing business. If this is the same as the legal name, also enter the legal name here.

4. Enter the hospital's general business phone number in item 4. Enter the area code in the parentheses.

5. If the hospital has a Medi-Cal contract, enter the Medi-Cal contract provider number in item 5 and the contract period in items 27 and 28. This is a nine-place number including a three-letter prefix and a one letter suffix (e.g. HSC12345F).

6. If the hospital is a Medi-Cal non-contract provider, or is a contract provider but also has certain services which are provided to Medi-Cal patients on a non-contract basis, enter in item 6 the Medi-Cal 9-place provider number with a prefix of ZZT, ZZR, or HSP. This number can be found on the Medi-Cal provider agreement.

7. Enter in item 7 the 6 digit Medicare provider number of the hospital (e.g. XX-XXX).

8. Enter in item 8 the street address of the hospital, in item 9 the city in which the hospital is located, and in item 10 the zip code.

9. If the hospital's mailing address is different from the street address,

   enter that in items 11, 12 and 13. Do not enter the parent company's mailing address.

10. In items 14 and 15 enter the name and title of the chief executive officer. (The person in charge of the day-to-day operations of the hospital.)

11. Enter in items 16 and 17 and 18 the name and complete business phone number and FAX phone number of the person who completed the report and in items 19, 20, 21 and 22 the complete mailing address of that person. The Office will contact this person

    to answer questions on the disclosure report and return it to him/her for correction of discrepancies in the report pages 0 through 22.

12. Enter in item 23 the name of the hospital's parent organization, if any.

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13. If the hospital has changed names since submitting the previous report, enter previous name in item 24.

14. Enter in items 25 and 26 the beginning and ending dates of the reporting period. Unless the report is for a partial year, this will be the beginning and ending dates of the hospital's fiscal year. Do not use the Medicare reporting period if different from the hospital's fiscal year.

15. If the hospital had a Medi-Cal contract during the reporting period specified in items 25 and 26, enter in items 27 and 28 the beginning and ending dates of the Medi-Cal contract period. Unless the hospital entered into a contract or canceled its contract with the Medi-Cal program during the reporting period, the dates will be the same as those entered in items 25 and 26.

16. Answer line 29 Ayes≅ if the disclosure report was completed after an independent financial audit.

17. Answer line 30 Ayes≅ if audit adjustments made by the independent auditor are reflected in the disclosure report.

18. The certification is to be read, prepared, and signed by the hospital administrator or other authorized official of the hospital after all report pages have been completed. The person signing the certification should be aware of its contents, that the certification is being made under the penalty of perjury.

19. If the report forms were manually completed, mail the original and one copy of the completed report. If the report was completed using one of the Office-approved PC diskette systems, send only one copy of the appropriate diskette and two signed copies of the system-produced certification. You do not need to send a copy of the system-generated facsimile report. Mail the completed report package to:

Office of Statewide Health Planning and Development
Health Facility Data Division
818 K Street, Room 400
Sacramento, CA 95814

All pages submitted but not completed must be marked N/A for not applicable".

REPORTING FORMS 7030

The following is a reproduction of the Annual Disclosure Report.